The Journal OF THE House of Representatives

Number 31 **Thursday, April 15, 2010**

The House was called to order by the Speaker at 12:45 p.m.

Prayer

The following prayer was offered by Pastor Henoc Paulicin of Ambassador Seventh-Day Adventist Church of Lauderdale Lakes, upon invitation of Rep. Rogers:

Heavenly Father, Creator of heaven and earth, the seas, and all that in them is. We come before You with thanksgiving in our hearts and desire to acknowledge the fact that You're supreme, and there is none like You. You alone are worthy of worship, praise, and adoration. We come to offer appreciation to You for the mercy and kindness received from You, and we recognize that such undeserved mercies are a testament of Your love and grace.

We invite Your presence among us. We desire to receive divine protection from evil—seen and unseen—and we wish to have Your guidance. We beseech You to impart a spirit of collegiality and cooperation. We pray for a heart that is willing to overlook differences and past hurts, so that we may work with others in earnestness and in sincerity. Remove all obstacles that would hinder us from coming together for the good of the people that You have called us to serve.

We need Your wisdom and guidance as we go forward, and we pray that a spirit of unity may be found in this place. We pray that we may strive to be the best that we can be as we perform our assigned duties. We pray that the welfare of others may be at the forefront of our minds. We pray for a selfless spirit, compassionate heart, and a soul filled with wisdom.

And when all is said and done, may the work that is done in this place be pleasing in Your sight, and may peace find permanent residence in these chambers. Hear us as we offer this prayer to You in anticipation, that the words of our mouths and the meditation of our hearts would be acceptable in Your sight. This we ask on this day. Amen.

The following members were recorded present:

Session Vote Sequence: 771

Speaker Cretul in the Chair.

Abruzzo	Bogdanoff	Cannon	Cruz
Adams	Bovo	Carroll	Culp
Adkins	Boyd	Chestnut	Domino
Anderson	Brandenburg	Clarke-Reed	Dorworth
Aubuchon	Bullard	Coley	Drake
Bembry	Burgin	Cretul	Eisnaugle
Bernard	Bush	Crisafulli	Evers
Fetterman	Hukill	Planas	Schwartz
Fitzgerald	Jenne	Poppell	Skidmore
Flores	Jones	Porth	Snyder
Ford	Kelly	Precourt	Soto
Fresen	Kiar	Proctor	Stargel
Frishe	Kreegel	Rader	Steinberg
Galvano	Kriseman	Ray	Taylor
Garcia	Legg	Reagan	Thompson, G.
Gibbons	Llorente	Reed	Thompson, N.
Gibson	Long	Rehwinkel Vasilinda	Thurston
Glorioso	Lopez-Cantera	Renuart	Tobia
Gonzalez	Mayfield	Rivera	Troutman
Grady	McBurney	Robaina	Waldman
Grimsley	McKeel	Roberson, K.	Weatherford
Hasner	Murzin	Roberson, Y.	Williams, A.
Hays	Nehr	Rogers	Williams, T.
Heller	Nelson	Rouson	Wood
Holder	O'Toole	Sachs	Workman
Homan	Pafford	Sands	Zapata
Hooper	Patronis	Saunders	
Horner	Patterson	Schenck	
Hudson	Plakon	Schultz	

(A list of excused members appears at the end of the *Journal.*)

A quorum was present.

Pledge

The members, led by the following, pledged allegiance to the Flag: Anya Klumpp of Davie at the invitation of Rep. Hudson; Savanna McDonald of Tallahassee at the invitation of Rep. Jenne; Ronald Renuart, Jr. of Ponte Vedra Beach at the invitation of his father, Rep. Renuart; Daniel Reyna of Pembroke Pines at the invitation of Rep. Lopez-Cantera; Mindell Robinson of Live Oak at the invitation of Rep. Boyd; and Broderick Schwinghammer of Miami Lakes at the invitation of Rep. Rivera.

Motion

Rep. Soto moved that Rep. Gaetz be seated as a member of the Florida House upon taking the Oath of Office. The motion was agreed to.

Oath of Office Administered

The Speaker requested that Rep. Gaetz approach the well for the administration of the Oath of Office.

The Clerk of the House, Bob Ward, administered the Oath of Office prescribed by the Constitution.

The Speaker welcomed the new member of the Florida House of Representatives and recognized him for brief remarks.

Motion

Rep. Workman requested permission to approach the well. The motion was agreed to.

Bronze Star Ceremony

Rep. Workman introduced Brigadier General Don Tyre, Mr. Todd Berlinghof, and Colonel Mike Canzoneri, and requested permission for them to approach the well. The motion was agreed to.

Brigadier General Tyre, Mr. Berlinghof, and Colonel Canzoneri approached the well, and were recognized to publish the orders, conduct a pinning ceremony, and present the Bronze Star.

Rep. Workman was recognized to make brief closing remarks, and introduced Mr. Berlinghof's family seated in the gallery. Brigadier General Tyre and Mr. Berlinghof made brief remarks from the well.

Mr. Berlinghof presented the Flag of the State of Florida, flown over Afghanistan during Operation Enduring Freedom, to the Speaker from the rostrum. The Speaker, on behalf of the Florida House of Representatives, received the Flag.

Correction of the *Journal*

The *Journals* of April 13 and April 14 were corrected and approved as corrected.

Reports of Standing Councils and Committees

Reports of the Rules & Calendar Council

The Honorable Larry Cretul April 13, 2010
Speaker, House of Representatives

Dear Mr. Speaker:

Your Rules & Calendar Council herewith submits the Special Order for Thursday, April 15, 2010. Consideration of the House bills on Special Orders shall include the Senate Companion measures on the House Calendar.

I. Consideration of the following bills:

HB 7079 - Governmental Affairs Policy Committee, Frishe
OGSR/Voter Information

HB 7085 - Governmental Affairs Policy Committee, Roberson, K.
OGSR/Commission on Ethics

HB 7087 - Governmental Affairs Policy Committee, Holder
OGSR/Guardians Ad Litem

HB 7089 - Governmental Affairs Policy Committee, Holder
OGSR/Florida Self-Insurers Guaranty Association

HB 7091 - Governmental Affairs Policy Committee, McBurney
OGSR/Insurance Claim Data Exchange Information/DOR

HB 7093 - Governmental Affairs Policy Committee, Mayfield
OGSR/Domestic Security Oversight Council

HB 7111 - Governmental Affairs Policy Committee, Holder
OGSR/Information Held by Guardians Ad Litem

HB 7113 - Governmental Affairs Policy Committee, McBurney
OGSR/State Child Abuse Death Review Committee

HB 7115 - Governmental Affairs Policy Committee, Ambler
OGSR/Identification of Minor/Waiver of Termination of Pregnancy Notification

HB 7117 - Governmental Affairs Policy Committee, Kreegel
OGSR/Board of Funeral, Cemetery, & Consumer Services

HB 7119 - Governmental Affairs Policy Committee, Roberson, K.
OGSR/Florida Commission on Hurricane Loss Projection Methodology

HB 7121 - Governmental Affairs Policy Committee, Roberson, K.
OGSR/Hurricane Loss and Exposure Data

HB 7123 - Governmental Affairs Policy Committee, Mayfield
OGSR/Address Confidentiality Program for Victims of Domestic Violence

CS/HB 7165 - Economic Development & Community Affairs Policy Council, Governmental Affairs Policy Committee, & others
OGSR/Domestic Violence Fatality Review Teams

HB 7167 - Governmental Affairs Policy Committee, Mayfield
OGSR/Commission for Independent Education

HB 7193 - Governmental Affairs Policy Committee, Braynon
OGSR/Voluntary Prekindergarten Education Program

HB 7223 - Select Policy Council on Strategic & Economic Planning, Grimsley
Medicaid Managed Care

HB 7225 - Select Policy Council on Strategic & Economic Planning, Grimsley
Medicaid

A quorum was present in person, and a majority of those present agreed to the above Report.

Respectfully submitted,
Bill Galvano, Chair
Rules & Calendar Council

On motion by Rep. Galvano, the above report was adopted.

Motions Relating to Council and Committee References

Rep. Waldman moved that **HB 7223** and **HB 7225** be referred to the Health & Family Services Policy Council, Health Care Appropriations Committee, and any other councils or committees deemed necessary by the Speaker.

The Chair [Speaker Cretul] referred the motion to Rep. Galvano, Chair of the Rules & Calendar Council, for a recommendation.

Rep. Galvano, Chair of the Rules & Calendar Council, in speaking to the motion, recommended that pursuant to Rule 11.12, the motion be taken up and voted on. Rep. Galvano, Chair of the Rules & Calendar Council, explained that the motion required a majority vote and contained a limitation on debate as to the propriety of the reference.

The Chair [Speaker Cretul], upon the recommendation of Rep. Galvano, ruled that debate as to the propriety of the reference be heard and voted on. The motion was not approved.

Bills and Joint Resolutions on Third Reading

CS for CS for SB 350—A bill to be entitled An act relating to tomato food safety; amending s. 500.03, F.S.; revising the term "food establishment" to include tomato repackers for purposes of the Florida Food Safety Act; creating s. 500.70, F.S.; defining terms; requiring minimum food safety standards for producing, harvesting, packing, and repacking tomatoes; authorizing the Department of Agriculture and Consumer Services to inspect tomato farms, greenhouses, and packinghouses or repackers; providing penalties; authorizing the department to establish good agricultural practices and best management practices for the tomato industry by rule; providing a presumption that tomatoes introduced into commerce are safe for human consumption under certain circumstances; providing exemptions; authorizing the department to adopt rules; amending s. 570.07, F.S.; authorizing the department to adopt best management practices for agricultural production and food safety; amending s. 570.48, F.S.; revising duties of the Division of Fruit and Vegetables for tomato food safety inspections; providing an effective date.

—was read the third time by title. On passage, the vote was:

Session Vote Sequence: 772

Speaker Cretul in the Chair.

Yeas—114

Abruzzo	Fitzgerald	Legg	Roberson, Y.
Adams	Flores	Llorente	Rogers
Adkins	Ford	Long	Rouson
Anderson	Fresen	Lopez-Cantera	Sachs
Aubuchon	Frishe	Mayfield	Sands
Bembry	Gaetz	McBurney	Saunders
Bernard	Galvano	McKeel	Schenck
Bogdanoff	Garcia	Murzin	Schultz
Bovo	Gibbons	Nehr	Schwartz
Boyd	Gibson	Nelson	Skidmore
Brandenburg	Glorioso	O'Toole	Snyder
Bullard	Gonzalez	Pafford	Soto
Burgin	Grady	Patronis	Stargel
Bush	Grimsley	Patterson	Steinberg
Cannon	Hasner	Plakon	Taylor
Carroll	Hays	Planas	Thompson, G.
Chestnut	Heller	Poppell	Thompson, N.
Clarke-Reed	Holder	Porth	Thurston
Coley	Homan	Precourt	Tobia
Cretul	Hooper	Proctor	Troutman
Crisafulli	Horner	Rader	Waldman
Cruz	Hudson	Ray	Weatherford
Culp	Hukill	Reagan	Williams, A.
Domino	Jenne	Reed	Williams, T.
Dorworth	Jones	Rehwinkel Vasilinda	Wood
Drake	Kelly	Renuart	Workman
Eisnaugle	Kiar	Rivera	Zapata
Evers	Kreegel	Robaina	
Fetterman	Kriseman	Roberson, K.	

Nays—None

Votes after roll call:
Yeas—Ambler, Randolph

So the bill passed and was certified to the Senate.

CS/HB 451—A bill to be entitled An act relating to Space Florida; creating s. 331.3081, F.S.; revising provisions for the governing board of Space Florida to terminate the existing board and replace it with a new board meeting the requirements of this section; providing for membership; providing for appointment of certain voting members by the Governor subject to confirmation by the Senate; providing for appointment of nonvoting members by the President of the Senate and the Speaker of the House of Representatives; providing for terms of the members and organization of the board; providing for reappointment or removal of members; providing for meetings and actions of the board; providing for reimbursement of expenses incurred by members and staff of the board; requiring members to file disclosure of financial interests; repealing s. 331.308, F.S., relating to the board of directors of Space Florida; providing an effective date.

—was read the third time by title.

On motion by Rep. Crisafulli, by the required two-thirds vote, the House agreed to consider the following late-filed amendment.

Representative Crisafulli offered the following:

(Amendment Bar Code: 000511)

Amendment 1 (with title amendment)—Remove line 49 and insert:
Governor's designee, who shall serve as chair of the board.

T I T L E A M E N D M E N T

Remove line 8 and insert:
confirmation by the Senate; providing for designation of a chair; providing for appointment of

Rep. Crisafulli moved the adoption of the amendment, which was adopted by the required two-thirds vote.

The question recurred on the passage of CS/HB 451. The vote was:

Session Vote Sequence: 773

Speaker Cretul in the Chair.

Yeas—114

Abruzzo	Fitzgerald	Legg	Roberson, K.
Adams	Flores	Llorente	Rogers
Adkins	Ford	Long	Rouson
Anderson	Fresen	Lopez-Cantera	Sachs
Aubuchon	Frishe	Mayfield	Sands
Bembry	Gaetz	McBurney	Saunders
Bernard	Galvano	McKeel	Schenck
Bogdanoff	Garcia	Murzin	Schultz
Bovo	Gibbons	Nehr	Schwartz
Boyd	Gibson	Nelson	Skidmore
Brandenburg	Glorioso	O'Toole	Snyder
Bullard	Gonzalez	Pafford	Soto
Burgin	Grady	Patronis	Stargel
Bush	Grimsley	Patterson	Steinberg
Cannon	Hasner	Plakon	Taylor
Carroll	Hays	Planas	Thompson, G.
Chestnut	Heller	Poppell	Thompson, N.
Clarke-Reed	Holder	Porth	Thurston
Coley	Homan	Precourt	Tobia
Cretul	Hooper	Proctor	Troutman
Crisafulli	Horner	Rader	Waldman
Cruz	Hudson	Randolph	Weatherford
Culp	Hukill	Ray	Williams, A.
Domino	Jenne	Reagan	Williams, T.
Dorworth	Jones	Reed	Wood
Drake	Kelly	Rehwinkel Vasilinda	Workman
Eisnaugle	Kiar	Renuart	Zapata
Evers	Kreegel	Rivera	
Fetterman	Kriseman	Robaina	

Nays—None

Votes after roll call:
Yeas—Ambler

So the bill passed, as amended, and was certified to the Senate after engrossment.

CS/HB 569—A bill to be entitled An act relating to landfills; amending s. 403.708, F.S.; authorizing the disposal of yard trash at specified Class I landfills; requiring such landfills to obtain a modified operating permit;

requiring permittees to certify certain collection and beneficial use of landfill gas; providing applicability; providing an effective date.

—was read the third time by title. On passage, the vote was:

Session Vote Sequence: 774

Speaker Cretul in the Chair.

Yeas—110

Abruzzo	Ford	Llorente	Rogers
Adams	Fresen	Long	Rouson
Adkins	Frishe	Lopez-Cantera	Sachs
Anderson	Gaetz	Mayfield	Sands
Aubuchon	Galvano	McBurney	Saunders
Bembry	Garcia	McKeel	Schenck
Bernard	Gibbons	Murzin	Schultz
Bogdanoff	Gibson	Nehr	Schwartz
Bovo	Glorioso	Nelson	Skidmore
Boyd	Gonzalez	O'Toole	Snyder
Brandenburg	Grady	Patronis	Soto
Burgin	Grimsley	Patterson	Stargel
Cannon	Hasner	Plakon	Steinberg
Carroll	Hays	Planas	Taylor
Chestnut	Heller	Poppell	Thompson, G.
Clarke-Reed	Holder	Porth	Thompson, N.
Coley	Homan	Precourt	Thurston
Cretul	Hooper	Proctor	Tobia
Crisafulli	Horner	Randolph	Troutman
Culp	Hudson	Ray	Waldman
Domino	Hukill	Reagan	Weatherford
Dorworth	Jenne	Reed	Williams, A.
Drake	Jones	Rehwinkel Vasilinda	Williams, T.
Eisnaugle	Kelly	Renuart	Wood
Evers	Kiar	Rivera	Workman
Fetterman	Kreegel	Robaina	Zapata
Fitzgerald	Kriseman	Roberson, K.	
Flores	Legg	Roberson, Y.	

Nays—5

Bullard	Cruz	Rader
Bush	Pafford	

Votes after roll call:
Yeas—Ambler

So the bill passed, as amended, and was certified to the Senate.

CS/HB 1225—A bill to be entitled An act relating to sewage disposal facilities; amending s. 403.086, F.S.; requiring entities that divert wastewater flows from facilities discharging wastewater through ocean outfalls to meet specified reuse requirements; providing for the recalculation of specified reuse requirements for facilities from which such flows are diverted; providing an effective date.

—was read the third time by title. On passage, the vote was:

Session Vote Sequence: 775

Speaker Cretul in the Chair.

Yeas—113

Abruzzo	Boyd	Coley	Evers
Adams	Brandenburg	Cretul	Fitzgerald
Adkins	Bullard	Crisafulli	Flores
Anderson	Burgin	Cruz	Ford
Aubuchon	Bush	Culp	Fresen
Bembry	Cannon	Domino	Frishe
Bernard	Carroll	Dorworth	Gaetz
Bogdanoff	Chestnut	Drake	Galvano
Bovo	Clarke-Reed	Eisnaugle	Garcia
Gibbons	Kriseman	Proctor	Skidmore
Gibson	Legg	Rader	Snyder
Glorioso	Llorente	Randolph	Soto
Gonzalez	Long	Ray	Stargel
Grady	Lopez-Cantera	Reagan	Steinberg
Grimsley	Mayfield	Reed	Taylor
Hasner	McBurney	Rehwinkel Vasilinda	Thompson, G.
Hays	McKeel	Renuart	Thompson, N.
Heller	Murzin	Rivera	Thurston
Holder	Nehr	Robaina	Troutman
Homan	Nelson	Roberson, K.	Waldman
Hooper	O'Toole	Roberson, Y.	Weatherford
Horner	Pafford	Rogers	Williams, A.
Hudson	Patronis	Rouson	Williams, T.
Hukill	Patterson	Sachs	Wood
Jenne	Plakon	Sands	Workman
Jones	Planas	Saunders	Zapata
Kelly	Poppell	Schenck	
Kiar	Porth	Schultz	
Kreegel	Precourt	Schwartz	

Nays—None

Votes after roll call:
Yeas—Ambler, Fetterman

So the bill passed and was certified to the Senate.

CS/HB 1537 was temporarily postponed.

CS/CS/HB 747—A bill to be entitled An act relating to the treatment of diabetes; amending s. 385.203, F.S.; revising the Diabetes Advisory Council membership; amending s. 1002.20, F.S.; prohibiting school districts from restricting the assignment of diabetic students to certain schools for certain reasons; authorizing a student to manage diabetes while at school, at school-sponsored activities, or in transit to or from school or school-sponsored activities with written authorization from the parent and physician; requiring the State Board of Education to adopt rules; providing for indemnification of specified employees, volunteers, and entities; providing an effective date.

—was read the third time by title. On passage, the vote was:

Session Vote Sequence: 776

Speaker Cretul in the Chair.

Yeas—113

Abruzzo	Fitzgerald	Kriseman	Rivera
Adams	Flores	Legg	Robaina
Adkins	Ford	Llorente	Roberson, K.
Anderson	Fresen	Long	Roberson, Y.
Aubuchon	Frishe	Lopez-Cantera	Rogers
Bembry	Gaetz	Mayfield	Sachs
Bernard	Galvano	McBurney	Sands
Bogdanoff	Garcia	McKeel	Saunders
Bovo	Gibbons	Murzin	Schenck
Boyd	Gibson	Nehr	Schultz
Brandenburg	Glorioso	Nelson	Schwartz
Bullard	Gonzalez	O'Toole	Skidmore
Bush	Grady	Pafford	Snyder
Cannon	Grimsley	Patronis	Soto
Carroll	Hasner	Patterson	Stargel
Chestnut	Hays	Plakon	Steinberg
Clarke-Reed	Heller	Planas	Taylor
Coley	Holder	Poppell	Thompson, G.
Cretul	Homan	Porth	Thompson, N.
Crisafulli	Hooper	Precourt	Thurston
Cruz	Horner	Proctor	Tobia
Culp	Hudson	Rader	Troutman
Domino	Hukill	Randolph	Waldman
Dorworth	Jenne	Ray	Weatherford
Drake	Jones	Reagan	Williams, A.
Eisnaugle	Kelly	Reed	Williams, T.
Evers	Kiar	Rehwinkel Vasilinda	Wood
Fetterman	Kreegel	Renuart	Workman

Zapata

Nays—None

Votes after roll call:
Yeas—Ambler, Burgin

So the bill passed and was certified to the Senate.

CS/HB 1101—A bill to be entitled An act relating to misdemeanor pretrial substance abuse programs; amending s. 948.16, F.S.; providing that a person who has previously been admitted to a pretrial program may qualify for the program; providing an effective date.

—was read the third time by title. On passage, the vote was:

Session Vote Sequence: 777

Speaker Cretul in the Chair.

Yeas—113

Abruzzo	Fitzgerald	Legg	Roberson, Y.
Adams	Flores	Llorente	Rogers
Adkins	Ford	Long	Sachs
Anderson	Fresen	Lopez-Cantera	Sands
Aubuchon	Frishe	Mayfield	Saunders
Bembry	Gaetz	McBurney	Schenck
Bernard	Galvano	McKeel	Schultz
Bogdanoff	Garcia	Murzin	Schwartz
Bovo	Gibbons	Nehr	Skidmore
Boyd	Gibson	Nelson	Snyder
Brandenburg	Glorioso	O'Toole	Soto
Bullard	Gonzalez	Pafford	Stargel
Burgin	Grady	Patterson	Steinberg
Bush	Grimsley	Plakon	Taylor
Cannon	Hasner	Planas	Thompson, G.
Carroll	Hays	Poppell	Thompson, N.
Chestnut	Heller	Porth	Thurston
Clarke-Reed	Holder	Precourt	Tobia
Coley	Homan	Proctor	Troutman
Cretul	Hooper	Rader	Waldman
Crisafulli	Horner	Randolph	Weatherford
Cruz	Hudson	Ray	Williams, A.
Culp	Hukill	Reagan	Williams, T.
Domino	Jenne	Reed	Wood
Dorworth	Jones	Rehwinkel Vasilinda	Workman
Drake	Kelly	Renuart	Zapata
Eisnaugle	Kiar	Rivera	
Evers	Kreegel	Robaina	
Fetterman	Kriseman	Roberson, K.	

Nays—None

Votes after roll call:
Yeas—Ambler, Patronis

So the bill passed and was certified to the Senate.

Moment of Silence

At the request of Rep. Carroll, the House observed a moment of silence in memory of Benjamin L. Hooks, a civil rights leader and the Executive Director of the National Association for the Advancement of Colored People from 1977 to 1992, who died today at the age of 85.

CS/HB 1281—A bill to be entitled An act relating to loan origination; amending s. 494.00255, F.S.; reenacting a reference to certain federal laws for purposes of incorporating rules adopted under such laws; specifying application of disciplinary procedures to principal loan originators for actions of loan originators; amending s. 494.00331, F.S.; specifying nonapplication of certain limitations to licensed loan originators operating solely as loan processors; providing a definition; prohibiting acting as a loan processor unless licensed as a loan originator; requiring a declaration of intent to engage solely in loan processing; authorizing withdrawal of a declaration of intent; authorizing payment of a loan processor's fee without violating certain restrictions; creating s. 494.00335, F.S.; exempting certain mobile home dealers licensed under ch. 494 and ch. 320, F.S., from licensure under ch. 520, F.S.; providing that certain mobile home dealer employees are not loan originators; amending s. 494.0038, F.S.; revising requirements relating to a good faith estimate by a loan originator; requiring a disclosure document to be signed and dated by the borrower; amending s. 494.0067, F.S.; deleting a requirement for licensure application prior to certain purchases or acquisitions under certain conditions; providing an effective date.

—was read the third time by title.

Representative Workman offered the following:

(Amendment Bar Code: 013005)

Amendment 1 (with title amendment)—Remove lines 88-100

T I T L E A M E N D M E N T

Remove lines 15-19 and insert:
violating certain restrictions; amending s. 494.0038, F.S.;

Rep. Workman moved the adoption of the amendment, which was adopted by the required two-thirds vote.

The question recurred on the passage of CS/HB 1281. The vote was:

Session Vote Sequence: 778

Speaker Cretul in the Chair.

Yeas—114

Abruzzo	Fitzgerald	Legg	Roberson, Y.
Adams	Flores	Llorente	Rogers
Adkins	Ford	Long	Rouson
Anderson	Fresen	Lopez-Cantera	Sachs
Aubuchon	Frishe	Mayfield	Sands
Bembry	Gaetz	McBurney	Saunders
Bernard	Galvano	McKeel	Schenck
Bogdanoff	Garcia	Murzin	Schultz
Bovo	Gibbons	Nehr	Schwartz
Boyd	Gibson	Nelson	Skidmore
Brandenburg	Glorioso	Pafford	Snyder
Bullard	Gonzalez	Patronis	Soto
Burgin	Grady	Patterson	Stargel
Bush	Grimsley	Plakon	Steinberg
Cannon	Hasner	Planas	Taylor
Carroll	Hays	Poppell	Thompson, G.
Chestnut	Heller	Porth	Thompson, N.
Clarke-Reed	Holder	Precourt	Thurston
Coley	Homan	Proctor	Tobia
Cretul	Hooper	Rader	Troutman
Crisafulli	Horner	Randolph	Waldman
Cruz	Hudson	Ray	Weatherford
Culp	Hukill	Reagan	Williams, A.
Domino	Jenne	Reed	Williams, T.
Dorworth	Jones	Rehwinkel Vasilinda	Wood
Drake	Kelly	Renuart	Workman
Eisnaugle	Kiar	Rivera	Zapata
Evers	Kreegel	Robaina	
Fetterman	Kriseman	Roberson, K.	

Nays—None

Votes after roll call:
Yeas—Ambler, O'Toole

So the bill passed, as amended, and was certified to the Senate after engrossment.

CS/HB 143—A bill to be entitled An act relating to an exemption for aircraft assembly and manufacturing hangars from comprehensive plan transportation concurrency requirements; amending s. 163.3180, F.S.; exempting hangars used to assemble or manufacture aircraft from certain transportation concurrency requirements; providing an effective date.

—was read the third time by title. On passage, the vote was:

Session Vote Sequence: 779

Speaker Cretul in the Chair.

Yeas—114

Abruzzo	Fitzgerald	Legg	Roberson, K.
Adams	Flores	Llorente	Roberson, Y.
Adkins	Ford	Long	Rogers
Anderson	Fresen	Lopez-Cantera	Sachs
Aubuchon	Frishe	Mayfield	Sands
Bembry	Gaetz	McBurney	Saunders
Bernard	Galvano	McKeel	Schenck
Bogdanoff	Garcia	Murzin	Schultz
Bovo	Gibbons	Nehr	Schwartz
Boyd	Gibson	Nelson	Skidmore
Brandenburg	Glorioso	O'Toole	Snyder
Bullard	Gonzalez	Pafford	Soto
Burgin	Grady	Patronis	Stargel
Bush	Grimsley	Patterson	Steinberg
Cannon	Hasner	Plakon	Taylor
Carroll	Hays	Planas	Thompson, G.
Chestnut	Heller	Poppell	Thompson, N.
Clarke-Reed	Holder	Porth	Thurston
Coley	Homan	Precourt	Tobia
Cretul	Hooper	Proctor	Troutman
Crisafulli	Horner	Rader	Waldman
Cruz	Hudson	Randolph	Weatherford
Culp	Hukill	Ray	Williams, A.
Domino	Jenne	Reagan	Williams, T.
Dorworth	Jones	Reed	Wood
Drake	Kelly	Rehwinkel Vasilinda	Workman
Eisnaugle	Kiar	Renuart	Zapata
Evers	Kreegel	Rivera	
Fetterman	Kriseman	Robaina	

Nays—None

Votes after roll call:
Yeas—Ambler

So the bill passed and was certified to the Senate.

CS/HB 1291—A bill to be entitled An act relating to domestic violence fatality review teams; amending s. 741.316, F.S.; deleting a requirement that the Governor's Task Force on Domestic Violence provide information and technical assistance to local domestic violence fatality review teams; providing that information and records acquired by a domestic violence fatality review team are not subject to discovery or introduction into evidence in criminal or administrative proceedings in certain circumstances; providing that a person who has attended a meeting of a domestic violence fatality review team may not testify in criminal or administrative proceedings as to certain records or information produced or presented to the team; providing an effective date.

—was read the third time by title. On passage, the vote was:

Session Vote Sequence: 780

Speaker Cretul in the Chair.

Yeas—111

Adams	Flores	Legg	Robaina
Adkins	Ford	Llorente	Roberson, K.
Anderson	Fresen	Long	Roberson, Y.
Aubuchon	Frishe	Lopez-Cantera	Rogers
Bembry	Gaetz	Mayfield	Sachs
Bernard	Galvano	McBurney	Sands
Bogdanoff	Garcia	McKeel	Schenck
Bovo	Gibbons	Murzin	Schultz
Boyd	Gibson	Nehr	Schwartz
Brandenburg	Glorioso	Nelson	Skidmore
Bullard	Gonzalez	O'Toole	Snyder
Burgin	Grady	Pafford	Soto
Bush	Grimsley	Patronis	Stargel
Cannon	Hasner	Patterson	Steinberg
Carroll	Hays	Plakon	Taylor
Chestnut	Heller	Planas	Thompson, G.
Clarke-Reed	Holder	Poppell	Thompson, N.
Coley	Homan	Porth	Thurston
Crisafulli	Hooper	Precourt	Tobia
Cruz	Horner	Proctor	Troutman
Culp	Hudson	Rader	Waldman
Domino	Hukill	Randolph	Weatherford
Dorworth	Jenne	Ray	Williams, A.
Drake	Jones	Reagan	Williams, T.
Eisnaugle	Kelly	Reed	Wood
Evers	Kiar	Rehwinkel Vasilinda	Workman
Fetterman	Kreegel	Renuart	Zapata
Fitzgerald	Kriseman	Rivera	

Nays—None

Votes after roll call:
Yeas—Ambler, Cretul, Saunders

So the bill passed and was certified to the Senate.

CS/HB 7099—A bill to be entitled An act relating to legislative reauthorizations; reauthorizing certain exemptions, 2-year extensions, and local comprehensive plan amendments granted, authorized, or adopted under general law and in effect as of a certain date; providing construction; providing for retroactive application; providing an effective date.

—was read the third time by title. On passage, the vote was:

Session Vote Sequence: 781

Speaker Cretul in the Chair.

Yeas—111

Abruzzo	Evers	Kiar	Reed
Adams	Fetterman	Kreegel	Rehwinkel Vasilinda
Adkins	Fitzgerald	Kriseman	Renuart
Anderson	Flores	Legg	Rivera
Aubuchon	Ford	Llorente	Robaina
Bembry	Fresen	Long	Rogers
Bernard	Frishe	Lopez-Cantera	Sachs
Bogdanoff	Gaetz	Mayfield	Sands
Bovo	Galvano	McBurney	Saunders
Boyd	Garcia	McKeel	Schenck
Brandenburg	Gibbons	Murzin	Schultz
Bullard	Gibson	Nehr	Schwartz
Burgin	Glorioso	Nelson	Skidmore
Bush	Gonzalez	O'Toole	Snyder
Cannon	Grady	Pafford	Soto
Carroll	Grimsley	Patronis	Stargel
Chestnut	Hasner	Patterson	Steinberg
Clarke-Reed	Hays	Plakon	Taylor
Coley	Heller	Planas	Thompson, G.
Cretul	Holder	Poppell	Thompson, N.
Crisafulli	Homan	Porth	Thurston
Cruz	Hooper	Precourt	Tobia
Culp	Hudson	Proctor	Troutman
Domino	Hukill	Rader	Waldman
Dorworth	Jenne	Randolph	Weatherford
Drake	Jones	Ray	Williams, A.
Eisnaugle	Kelly	Reagan	Williams, T.

Wood	Workman	Zapata

Nays—None

Votes after roll call:
Yeas—Ambler, Horner, Roberson, K.

So the bill passed, as amended, and was certified to the Senate.

CS/HB 109—A bill to be entitled An act relating to the excise tax on documents; amending s. 201.02, F.S.; excluding certain unpaid indebtedness from the taxable consideration for short sales of real property; defining the term "short sale"; providing an effective date.

—was read the third time by title. On passage, the vote was:

Session Vote Sequence: 782

Speaker Cretul in the Chair.

Yeas—114

Abruzzo	Fitzgerald	Llorente	Roberson, Y.
Adams	Flores	Long	Rogers
Adkins	Ford	Lopez-Cantera	Rouson
Ambler	Fresen	Mayfield	Sachs
Anderson	Frishe	McBurney	Sands
Aubuchon	Gaetz	McKeel	Saunders
Bembry	Galvano	Murzin	Schenck
Bernard	Garcia	Nehr	Schultz
Bogdanoff	Gibbons	Nelson	Schwartz
Bovo	Gibson	O'Toole	Skidmore
Boyd	Glorioso	Pafford	Snyder
Brandenburg	Gonzalez	Patronis	Soto
Bullard	Grady	Patterson	Stargel
Burgin	Grimsley	Plakon	Steinberg
Bush	Hasner	Planas	Taylor
Cannon	Hays	Poppell	Thompson, G.
Carroll	Holder	Porth	Thompson, N.
Chestnut	Homan	Precourt	Thurston
Clarke-Reed	Hooper	Proctor	Tobia
Coley	Horner	Rader	Troutman
Cretul	Hudson	Randolph	Waldman
Crisafulli	Hukill	Ray	Weatherford
Cruz	Jenne	Reagan	Williams, A.
Culp	Jones	Reed	Williams, T.
Domino	Kelly	Rehwinkel Vasilinda	Wood
Dorworth	Kiar	Renuart	Workman
Drake	Kreegel	Rivera	Zapata
Eisnaugle	Kriseman	Robaina	
Evers	Legg	Roberson, K.	

Nays—None

Votes after roll call:
Yeas—Fetterman, Heller

So the bill passed and was certified to the Senate.

HB 7153—A bill to be entitled An act relating to the Open Government Sunset Review Act; amending ss. 27.151, 378.406, 400.0077, 403.111, and 655.0321, F.S.; correcting cross-references to a repealed section of Florida Statutes; providing an effective date.

—was read the third time by title. On passage, the vote was:

Session Vote Sequence: 783

Speaker Cretul in the Chair.

Yeas—116

Abruzzo	Fetterman	Kriseman	Robaina
Adams	Fitzgerald	Legg	Roberson, K.
Adkins	Flores	Llorente	Roberson, Y.
Ambler	Ford	Long	Rogers
Anderson	Fresen	Lopez-Cantera	Rouson
Aubuchon	Frishe	Mayfield	Sachs
Bembry	Gaetz	McBurney	Sands
Bernard	Galvano	McKeel	Saunders
Bogdanoff	Garcia	Murzin	Schenck
Bovo	Gibbons	Nehr	Schultz
Boyd	Gibson	Nelson	Schwartz
Brandenburg	Glorioso	O'Toole	Skidmore
Bullard	Gonzalez	Pafford	Snyder
Burgin	Grady	Patronis	Soto
Bush	Grimsley	Patterson	Stargel
Cannon	Hasner	Plakon	Steinberg
Carroll	Hays	Planas	Taylor
Chestnut	Heller	Poppell	Thompson, G.
Clarke-Reed	Holder	Porth	Thompson, N.
Coley	Homan	Precourt	Thurston
Cretul	Hooper	Proctor	Tobia
Crisafulli	Horner	Rader	Troutman
Cruz	Hudson	Randolph	Waldman
Culp	Hukill	Ray	Weatherford
Domino	Jenne	Reagan	Williams, A.
Dorworth	Jones	Reed	Williams, T.
Drake	Kelly	Rehwinkel Vasilinda	Wood
Eisnaugle	Kiar	Renuart	Workman
Evers	Kreegel	Rivera	Zapata

Nays—None

So the bill passed and was certified to the Senate.

CS/CS/HB 119—A bill to be entitled An act relating to sexual offenders and predators; creating s. 856.022, F.S.; prohibiting loitering or prowling by certain offenders within a specified distance of places where children were congregating; prohibiting certain actions toward a child at a public park or playground by certain offenders; prohibiting the presence of certain offenders at or on real property comprising a child care facility or prekindergarten through grade 12 school without notice and supervision; providing exceptions; providing penalties; amending s. 775.21, F.S.; revising and providing definitions; conforming terminology to changes made by the act; revising provisions relating to residence reporting requirements for sexual predators; transferring, renumbering, and amending s. 794.065, F.S.; providing definitions; substituting the term "child care facility" for the term "day care center"; providing that the section does not apply to a person living in an approved residence before the establishment of a school, child care facility, park, or playground within 1,000 feet of the residence; including offenses in other jurisdictions that are similar to the offenses listed for purposes of providing residency restrictions for persons convicted of certain sex offenses, applicable to offenses committed on or after a specified date; providing that the section does not apply to persons who were removed from the requirement to register as a sexual offender or sexual predator under a specified provision; amending s. 943.0435, F.S.; revising provisions relating to residence reporting requirements for sexual offenders; amending s. 943.04352, F.S.; requiring that the probation services provider search in an additional specified sex offender registry for information regarding sexual predators and sexual offenders when an offender is placed on misdemeanor probation; amending s. 943.04354, F.S.; allowing the removal of the requirement to register as a sexual offender or sexual predator for a violation involving sexual performance by a child in special circumstances; amending s. 944.606, F.S.; revising address reporting requirements for sexual offenders; amending s. 944.607, F.S.; requiring additional registration information from sex offenders who are under the supervision of the Department of Corrections but who are not incarcerated; amending s. 947.005, F.S.; providing additional definitions; amending s. 947.1405, F.S.; conforming terminology to changes made by the act; providing that a releasee living in an approved residence before the establishment of a school, child care facility, park, or playground within 1,000 feet of the residence may not be forced to relocate and does not violate his or her conditional release supervision; revising provisions relating

to polygraph examinations of specified conditional releasees who have committed specified sexual offenses; providing additional restrictions for certain conditional releasees who have committed specified sexual offenses against minors or have similar convictions in another jurisdiction; amending s. 948.001, F.S.; revising and providing definitions; amending s. 948.30, F.S.; conforming terminology to changes made by the act; providing that a probationer or community controllee living in an approved residence before the establishment of a school, child care facility, park, or playground within 1,000 feet of the residence may not be forced to relocate and does not violate his or her probation or community control; revising provisions relating to polygraph examinations of specified probationers or community controllees who have committed specified sexual offenses; providing additional restrictions for certain probationers or community controllees who committed specified sexual offenses against minors or who have similar convictions in another jurisdiction; amending s. 948.31, F.S.; deleting a requirement for diagnosis of certain sexual predators and sexual offenders on community control; revising provisions relating to treatment for such offenders and predators; amending s. 985.481, F.S.; providing additional address reporting requirements for sexual offenders adjudicated delinquent; amending s. 985.4815, F.S.; revising provisions relating to address and residence reporting requirements for sexual offenders adjudicated delinquent; providing legislative intent; providing severability; providing a directive to the Division of Statutory Revision; providing an effective date.

—was read the third time by title. On passage, the vote was:

Session Vote Sequence: 784

Speaker Cretul in the Chair.

Yeas—115

Abruzzo	Fetterman	Kriseman	Roberson, K.
Adams	Fitzgerald	Legg	Roberson, Y.
Adkins	Flores	Llorente	Rogers
Ambler	Ford	Long	Rouson
Anderson	Fresen	Lopez-Cantera	Sachs
Aubuchon	Frishe	Mayfield	Sands
Bembry	Gaetz	McBurney	Saunders
Bernard	Galvano	McKeel	Schenck
Bogdanoff	Garcia	Murzin	Schultz
Bovo	Gibbons	Nehr	Schwartz
Boyd	Gibson	Nelson	Skidmore
Brandenburg	Glorioso	O'Toole	Snyder
Bullard	Gonzalez	Pafford	Soto
Burgin	Grady	Patronis	Stargel
Bush	Grimsley	Patterson	Steinberg
Cannon	Hasner	Plakon	Taylor
Carroll	Hays	Planas	Thompson, G.
Chestnut	Heller	Poppell	Thompson, N.
Clarke-Reed	Holder	Porth	Thurston
Coley	Homan	Precourt	Tobia
Cretul	Hooper	Proctor	Troutman
Crisafulli	Horner	Rader	Waldman
Cruz	Hudson	Ray	Weatherford
Culp	Hukill	Reagan	Williams, A.
Domino	Jenne	Reed	Williams, T.
Dorworth	Jones	Rehwinkel Vasilinda	Wood
Drake	Kelly	Renuart	Workman
Eisnaugle	Kiar	Rivera	Zapata
Evers	Kreegel	Robaina	

Nays—None

Votes after roll call:
Yeas—Randolph

So the bill passed, as amended, and was certified to the Senate.

Remarks

The Speaker recognized Rep. Bush, who made brief farewell remarks.

THE SPEAKER PRO TEMPORE IN THE CHAIR

Special Orders

HB 7079—A bill to be entitled An act relating to a review under the Open Government Sunset Review Act; amending s. 97.0585, F.S., which provides an exemption from public records requirements for certain information regarding voters and voter registration and which provides an exemption from the copying requirements for signatures of voters and voter registrants; making clarifying changes; repealing s. 3, ch. 2005-279, Laws of Florida, which provides for repeal of the exemption; providing an effective date.

—was read the second time by title and, under Rule 10.10(b), referred to the Engrossing Clerk.

HB 7085—A bill to be entitled An act relating to a review under the Open Government Sunset Review Act; amending s. 112.324, F.S., which provides an exemption from public records requirements for complaints and related records held by the Commission on Ethics or a Commission on Ethics and Public Trust established by a county or municipality and an exemption from public meetings requirements for proceedings conducted by such commissions pursuant to a complaint or preliminary investigation; reorganizing the exemption; removing the scheduled repeal of the exemption; providing an effective date.

—was read the second time by title and, under Rule 10.10(b), referred to the Engrossing Clerk.

HB 7087—A bill to be entitled An act relating to a review under the Open Government Sunset Review Act; amending s. 119.071, F.S., which provides an exemption from public records requirements for identification and location information of current or former guardians ad litem and the spouses and children of guardians ad litem; expanding the public records exemption to include the names and locations of schools or day care facilities attended by the children of current or former guardians ad litem; providing for future legislative review and repeal of the exemption; providing a statement of public necessity; providing an effective date.

—was read the second time by title and, under Rule 10.10(b), referred to the Engrossing Clerk.

HB 7089—A bill to be entitled An act relating to a review under the Open Government Sunset Review Act; amending s. 440.3851, F.S., which provides an exemption from public records and public meetings requirements for the Florida Self-Insurers Guaranty Association, Incorporated; reorganizing the section; removing the scheduled repeal of the exemptions; providing an effective date.

—was read the second time by title and, under Rule 10.10(b), referred to the Engrossing Clerk.

HB 7091—A bill to be entitled An act relating to a review under the Open Government Sunset Review Act; amending s. 409.25661, F.S., which provides an exemption from public records requirements for certain records obtained by the Department of Revenue under an insurance claim data exchange system; saving the exemption from repeal under the Open Government Sunset Review Act; extending the repeal date; providing an effective date.

—was read the second time by title and, under Rule 10.10(b), referred to the Engrossing Clerk.

HB 7093—A bill to be entitled An act relating to a review under the Open Government Sunset Review Act; amending s. 943.0314, F.S., which provides exemptions from public records and public meetings requirements for the Domestic Security Oversight Council, by repealing subsection (3) to remove the scheduled repeal of the exemptions; providing an effective date.

—was read the second time by title and, under Rule 10.10(b), referred to the Engrossing Clerk.

HB 7111—A bill to be entitled An act relating to a review under the Open Government Sunset Review Act; amending s. 39.0132, F.S., which provides an exemption from public records requirements for certain information regarding a child held by a guardian ad litem; clarifying and reorganizing the exemption; removing the scheduled repeal of the exemption; providing an effective date.

—was read the second time by title and, under Rule 10.10(b), referred to the Engrossing Clerk.

HB 7113—A bill to be entitled An act relating to a review under the Open Government Sunset Review Act; amending s. 383.412, F.S., which provides an exemption from public records requirements for information held or obtained by the State Child Abuse Death Review Committee or any local committee and an exemption from public meetings requirements for specified meetings of the committee or a local committee; defining the term "local committee"; reorganizing provisions; requiring any portion of a closed meeting to be recorded; providing a public records exemption for the recording of the closed meeting; providing a penalty; providing for future legislative review and repeal of the exemption; providing a statement of public necessity; providing an effective date.

—was read the second time by title and, under Rule 10.10(b), referred to the Engrossing Clerk.

HB 7115—A bill to be entitled An act relating to a review under the Open Government Sunset Review Act; amending s. 390.01116, F.S., which provides an exemption from public records requirements for information that could identify a minor which is contained in a record relating to a minor's petition to waive notice requirements when terminating a pregnancy; repealing s. 2, ch. 2005-104, Laws of Florida, which provides for repeal of the exemption; making editorial changes; expanding the exemption to include such information held by the office of criminal conflict and civil regional counsel or the Justice Administrative Commission; providing for future legislative review and repeal of the exemption under the Open Government Sunset Review Act; providing a statement of public necessity; providing an effective date.

—was read the second time by title and, under Rule 10.10(b), referred to the Engrossing Clerk.

HB 7117—A bill to be entitled An act relating to a review under the Open Government Sunset Review Act; amending s. 497.172, F.S., which provides exemptions from public meetings and public records requirements for the Board of Funeral, Cemetery, and Consumer Services within the Department of Financial Services and for certain information held by the Department of Financial Services; requiring a recording of a closed meeting of the board wherein licensure examination questions or answers are discussed; creating a public record exemption for a recording of the closed meeting; providing for future legislative review and repeal of the exemption; requiring a recording of a closed meeting of a probable cause panel of the board; removing the scheduled repeal of exemptions within the section; providing a statement of public necessity; providing an effective date.

—was read the second time by title and, under Rule 10.10(b), referred to the Engrossing Clerk.

HB 7119—A bill to be entitled An act relating to a review under the Open Government Sunset Review Act; amending s. 627.0628, F.S.; clarifying the public records exemption for a trade secret used in designing and constructing a hurricane loss model and provided by a private company to the Florida Commission on Hurricane Loss Projection Methodology, the Office of Insurance Regulation, or an appointed consumer advocate to specify that the exemption applies to trade secrets as defined in the Uniform Trade Secrets Act; requiring a recording of a closed meeting of the commission or of a rate proceeding on an insurer's rate filing at which confidential and exempt trade secrets are discussed; creating a public records exemption for the recording of the closed meeting; providing for future legislative review and repeal of the exemption; providing a statement of public necessity; providing an effective date.

—was read the second time by title and, under Rule 10.10(b), referred to the Engrossing Clerk.

HB 7121—A bill to be entitled An act relating to a review under the Open Government Sunset Review Act; amending s. 627.06292, F.S.; saving from scheduled repeal under the Open Government Sunset Review Act an exemption from public records requirements for specified reports of hurricane loss data and associated exposure data that are specific to a particular insurance company; requiring the Florida International University center that develops, maintains, and updates the public model for hurricane loss projections to publish an annual report summarizing loss data and associated exposure data collected from residential property insurers and licensed rating and advisory organizations; providing for submission of the report to the Governor and the Legislature; providing an effective date.

—was read the second time by title and, under Rule 10.10(b), referred to the Engrossing Clerk.

HB 7123—A bill to be entitled An act relating to a review under the Open Government Sunset Review Act; repealing s. 3, ch. 2005-279, Laws of Florida; saving from scheduled repeal under the Open Government Sunset Review Act exemptions from public records requirements for identifying information of participants in the Address Confidentiality Program for Victims of Domestic Violence under s. 741.465, F.S., held by the Office of the Attorney General and contained in voter registration and voting records held by the supervisor of elections and the Department of State; providing an effective date.

—was read the second time by title and, under Rule 10.10(b), referred to the Engrossing Clerk.

CS/HB 7165—A bill to be entitled An act relating to a review under the Open Government Sunset Review Act; repealing s. 741.3165(3), F.S.; removing the scheduled repeal of an exemption from public records requirements for specified identifying information in records created by a domestic violence fatality review team and an exemption from public meetings requirements for specified meetings of a domestic violence fatality review team; providing an effective date.

—was read the second time by title and, under Rule 10.10(b), referred to the Engrossing Clerk.

HB 7167—A bill to be entitled An act relating to a review under the Open Government Sunset Review Act; amending s. 1005.38, F.S., which provides an exemption from public records requirements for investigatory records held by the Commission for Independent Education and an exemption from public meetings requirements for a probable cause panel wherein exempt information is discussed; reorganizing the exemption; requiring a recording for any portion of a closed meeting of a probable cause panel; providing a public records exemption for the recording of a closed meeting of a probable cause panel and the minutes and findings of the meeting; providing for limited duration of the exemption; providing for future legislative review and repeal of the exemptions; providing a statement of public necessity; providing an effective date.

—was read the second time by title and, under Rule 10.10(b), referred to the Engrossing Clerk.

HB 7193—A bill to be entitled An act relating to a review under the Open Government Sunset Review Act; amending s. 1002.72, F.S., which provides an exemption from public records requirements for records of children in the Voluntary Prekindergarten Education Program; making editorial changes; reorganizing the section; removing the scheduled repeal of the exemption; providing an effective date.

—was read the second time by title and, under Rule 10.10(b), referred to the Engrossing Clerk.

HB 7223—A bill to be entitled An act relating to Medicaid managed care; creating pt. IV of ch. 409, F.S.; creating s. 409.961, F.S.; providing for statutory construction; providing applicability of specified provisions throughout the part; providing rulemaking authority for specified agencies; creating s. 409.962, F.S.; providing definitions; creating s. 409.963, F.S.; designating the Agency for Health Care Administration as the single state agency to administer the Medicaid program; providing for specified agency responsibilities; requiring client consent for release of medical records; creating s. 409.964, F.S.; establishing the Medicaid program as the statewide, integrated managed care program for all covered services; authorizing the agency to apply for and implement waivers; providing for public notice and comment; creating s. 409.965, F.S.; providing for mandatory enrollment; providing for exemptions; creating s. 409.966, F.S.; providing requirements for qualified plans that provide services in the Medicaid managed care program; providing for a medical home network to be designated as a qualified plan; establishing provider service network requirements for qualified plans; providing for qualified plan selection; requiring the agency to use an invitation to negotiate; requiring the agency to compile and publish certain information; establishing regions for separate procurement of plans; providing quality selection criteria for plan selection; establishing quality selection criteria; providing limitations on serving recipients during the pendency of litigation; providing that a qualified plan that participates in an invitation to negotiate in more than one region may not serve Medicaid recipients until all administrative challenges are finalized; creating s. 409.967, F.S.; providing for managed care plan accountability; establishing contract terms; providing for contract extension under certain circumstances; establishing payments to noncontract providers; establishing requirements for access; requiring plans to establish and maintain an electronic database; establishing requirements for the database; requiring plans to provide encounter data; requiring the agency to establish performance standards for plans; providing program integrity requirements; establishing a grievance resolution process; providing for penalties for early termination of contracts or reduction in enrollment levels; creating s. 409.968, F.S.; establishing managed care plan payments; providing payment requirements for provider service networks; creating s. 409.969, F.S.; requiring enrollment in managed care plans by specified Medicaid recipients; creating requirements for plan selection by recipients; providing for choice counseling; establishing choice counseling requirements; authorizing disenrollment under certain circumstances; defining the term "good cause" for purposes of disenrollment; providing time limits on an internal grievance process; providing requirements for agency determination regarding disenrollment; requiring recipients to stay in plans for a specified time; creating s. 409.970, F.S.; requiring the agency to maintain an encounter data system; providing requirements for prepaid plans to submit data; creating s. 409.971, F.S.; creating the managed medical assistance program; providing deadlines to begin and finalize implementation of the program; creating s. 409.972, F.S.; providing for mandatory and voluntary enrollment; creating s. 409.973, F.S.; establishing minimum benefits for managed care plans to cover; authorizing plans to customize benefit packages; requiring plans to establish enhanced benefits programs; providing terms for enhanced benefits package; establishing reserve requirements for plans to fund enhanced benefits programs; creating s. 409.974, F.S.; establishing a specified number of qualified plans to be selected in each region; establishing a deadline for issuing invitations to negotiate; establishing quality selection criteria; establishing the Children's Medical Service Network as a qualified plan; creating s. 409.975; establishing managed care plan accountability; creating a medical loss ratio requirement; authorizing plans to limit providers in networks; mandating certain providers be offered contracts in the first year; requiring certain provider types to participate in plans; requiring plans to monitor the quality and performance history of providers; requiring specified programs and procedures be established by plans; establishing provider payments for hospitals; establishing conflict resolution procedures; establishing plan requirements for medically needy recipients; creating s. 409.976, F.S.; providing for managed care plan payment; requiring the agency to establish a methodology to ensure certain types of payments to specified providers; establishing eligibility for payments; creating s. 409.977, F.S.; providing for enrollment; establishing choice counseling requirements; providing for automatic enrollment of certain recipients; establishing opt-out opportunities for recipients; creating s. 409.978, F.S.; requiring the Agency for Health Care Administration be responsible for administering the long-term care managed care program; providing implementation dates for the long-term care managed care program; providing duties for the Department of Elderly Affairs relating to assisting the agency in implementing the program; creating s. 409.979, F.S.; providing eligibility requirements for the long-term care managed care program; creating s. 409.980, F.S.; providing the benefits that a managed care plan shall provide when participating in the long-term care managed care program; creating s. 409.981, F.S.; providing criteria for qualified plans; designating regions for plan implementation throughout the state; providing criteria for the selection of plans to participate in the long-term care managed care program; creating s. 409.982, F.S.; providing the agency shall establish a uniform accounting and reporting methods for plans; providing spending thresholds and consequences relating to spending thresholds; providing for mandatory participation in plans of certain service providers; providing providers can be excluded from plans for failure to meet quality or performance criteria; providing the plans must monitor participating providers using specified criteria; providing certain providers that must be included in plan networks; providing provider payment specifications for nursing homes and hospices; creating s. 409.983, F.S.; providing for negotiation of rates between the agency and the plans participating in the long-term care managed care program; providing specific criteria for calculating and adjusting plan payments; allowing the CARES program to assign plan enrollees to a level of care ; providing incentives for adjustments of payment rates; providing the agency shall establish nursing facility-specific and hospice services payment rates; creating s. 409.984, F.S.; providing that prior to contracting with another vender, the agency shall offer to contract with the aging resource centers to provide choice counseling for the long-term care managed care program; providing criteria for automatic assignments of plan enrollees who fail to chose a plan; creating s. 409.985, F.S.; providing that the agency shall operate the Comprehensive Assessment and Review for Long-Term Care Services program through an interagency agreement with the Department of Elderly Affairs; providing duties of the program; defining the term "nursing facility care"; creating s. 409.986, F.S.; providing authority and agency duties related to long-term care plans; creating s. 409.987, F.S.; providing eligibility requirements for long-term care plans; creating s. 409.988, F.S.; providing benefits for long-term care plans; creating s. 409.989, F.S.; establishing criteria for qualified plans; specifying minimum and maximum number of plans and selection criteria; creating s. 409.990, F.S.; providing requirements for managed care plan accountability; specifying limitations on providers in plan networks; providing for evaluation and payment of network providers; creating s. 409.991, F.S.; providing for payment of managed care plans; providing duties for the Agency for Persons with Disabilities to assign plan enrollees into a payment rate level of care; establishing level of care criteria; providing payment requirements for intermediate care facilities for the developmentally disabled; creating s. 409.992, F.S.; providing requirements for enrollment and choice counseling; specifying enrollment exceptions for certain Medicaid recipients; providing an effective date.

—was read the second time by title.

THE SPEAKER IN THE CHAIR

The absence of a quorum was suggested. A quorum was present [Session Vote Sequence: 785].

Representative Jones offered the following:

(Amendment Bar Code: 385527)

Amendment 1 (with title amendment)—Between lines 162 and 163, insert:

Section 1. Section 409.110, Florida Statutes, is created to read:

409.110 Home medical equipment services.—Any health benefit plan that includes home medical equipment services as a benefit shall permit any home medical equipment provider licensed under chapter 400 who agrees to abide by the terms, conditions, reimbursement rates and standards of quality of the health benefit plan to serve as a participating home medical equipment provider to any person covered by the plan.

T I T L E A M E N D M E N T

Remove line 2 and insert:

An act relating to Medicaid managed care; creating s. 409.110, F.S.; requiring a health benefit plan that includes home medical equipment services as a benefit to permit certain home medical equipment providers to serve as a participating home medical equipment provider under certain conditions; creating pt. IV

Rep. Jones moved the adoption of the amendment, which failed of adoption.

On motion by Rep. Jones, by the required two-thirds vote, the House agreed to consider the following late-filed amendment.

Representative Jones offered the following:

(Amendment Bar Code: 779459)

Amendment 2—Remove line 285 and insert:

opportunity for public comment and shall include public feedback in the waiver application. The agency shall include the public feedback in the application. The agency shall hold one public meeting in each of the regions described in s. 409.966(2) and the time period for public comment for each region shall end no sooner than 30 days after the completion of the public meeting in that region.

Rep. Jones moved the adoption of the amendment, which was adopted.

On motion by Rep. Fitzgerald, by the required two-thirds vote, the House agreed to consider the following late-filed amendment.

Representative Fitzgerald offered the following:

(Amendment Bar Code: 528329)

Amendment 3—Remove lines 395-396 and insert:

the best value to the state. Preference shall be given to

Rep. Fitzgerald moved the adoption of the amendment, which was adopted.

On motion by Rep. Fitzgerald, by the required two-thirds vote, the House agreed to consider the following late-filed amendment.

Representative Fitzgerald offered the following:

(Amendment Bar Code: 751373)

Amendment 4—Remove line 462 and insert:

System. The agency shall develop methods and protocols for ongoing analysis of the encounter data that adjusts for differences in characteristics of plans' enrollees to allow comparison of service utilization among plans and against expected levels of use. The analysis shall be used to identify possible cases of systemic under-utilization or denials of claims and inappropriate service utilization such as higher than expected emergency department encounters. The analysis shall provide periodic feedback to the plans and enable the agency to establish corrective action plans when necessary. One of the primary focus areas for the analysis shall be the use of prescription drugs.

Rep. Fitzgerald moved the adoption of the amendment, which was adopted.

On motion by Rep. Jones, by the required two-thirds vote, the House agreed to consider the following late-filed amendment.

Representative Jones offered the following:

(Amendment Bar Code: 278761)

Amendment 5—Remove lines 484-492 and insert:

(f) Grievance resolution.—Each plan shall establish and the agency shall approve an internal process for reviewing and responding to grievances from enrollees consistent with the requirements of s. 641.511. Each plan shall submit quarterly reports on the number, description, and outcome of grievances filed by enrollees. The agency shall maintain a process for provider service networks consistent with s. 408.7056.

Rep. Jones moved the adoption of the amendment, which was adopted.

On motion by Rep. Jones, by the required two-thirds vote, the House agreed to consider the following late-filed amendment.

Representative Jones offered the following:

(Amendment Bar Code: 727969)

Amendment 6—Between lines 503 and 504, insert:

(h) Prompt payment.—For all electronically submitted claims, a managed care plan shall:

1. Within 24 hours after the beginning of the next business day after receipt of the claim, provide electronic acknowledgment of the receipt of the claim to the electronic source submitting the claim;

2. Within 20 days after receipt of the claim, pay the claim or notify the provider or designee if a claim is denied or contested. Notice of the organization's action on the claim and payment of the claim is considered to be made on the date the notice or payment was mailed or electronically transferred; and

3. Within 90 days after receipt of the claim, pay or deny the claim. Failure to pay or deny a claim within 120 days after receipt of the claim creates an uncontestable obligation to pay the claim.

Rep. Jones moved the adoption of the amendment, which was adopted.

On motion by Rep. Jones, by the required two-thirds vote, the House agreed to consider the following late-filed amendment.

Representative Jones offered the following:

(Amendment Bar Code: 443703)

Amendment 7—Between lines 503 and 504, insert:

(h) Electronic claims.-Plans shall accept electronic claims in compliance with federal standards.

Rep. Jones moved the adoption of the amendment, which was adopted.

On motion by Rep. Fitzgerald, by the required two-thirds vote, the House agreed to consider the following late-filed amendment.

Representative Fitzgerald offered the following:

(Amendment Bar Code: 910699)

Amendment 8—Between lines 503 and 504, insert:
(h) Medical home development.-The managed care plan, if not designated as a medical home network pursuant to s. 409.91207, must develop a plan to assist and to provide incentives for its primary care providers to become recognized as patient-centered medical homes by the National Committee for Quality Assurance.

Rep. Fitzgerald moved the adoption of the amendment, which was adopted.

On motion by Rep. Jones, by the required two-thirds vote, the House agreed to consider the following late-filed amendment.

Representative Jones offered the following:

(Amendment Bar Code: 959815)

Amendment 9—Remove lines 569-570 and insert:
for a period of 5 years. The agency may renew a contract for an additional 5-year period; however, prior to renewal of the contract the agency shall hold at least one public meeting in each of the regions covered by the choice counseling vendor. The agency may extend the term of the contract to

Rep. Jones moved the adoption of the amendment, which was adopted.

On motion by Rep. Fitzgerald, by the required two-thirds vote, the House agreed to consider the following late-filed amendment.

Representative Brisé offered the following:

(Amendment Bar Code: 458073)

Amendment 10—Remove lines 571-573 and insert:
cover any delays in transition to a new contractor. Printed choice information and choice counseling shall be offered in the native or preferred language of the recipient, consistent with federal requirements. The manner and method of choice counseling shall be modified as necessary to assure culturally competent, effective communication with people from diverse cultural backgrounds. The

Rep. Fitzgerald moved the adoption of the amendment, which was adopted.

On motion by Rep. Chestnut, by the required two-thirds vote, the House agreed to consider the following late-filed amendment.

Representative Chestnut offered the following:

(Amendment Bar Code: 123519)

Amendment 11—Between lines 625 and 626, insert:
(d) On the first day of the next month after receiving notice from a recipient that the recipient has moved to another region, the agency shall automatically disenroll the recipient from the plan the recipient is currently enrolled in and treat the recipient as if the recipient is a new Medicaid enrollee. At that time, the recipient may choose another plan pursuant to the enrollment process established in this section.

Rep. Chestnut moved the adoption of the amendment, which was adopted.

On motion by Rep. Fitzgerald, by the required two-thirds vote, the House agreed to consider the following late-filed amendment.

Representative Fitzgerald offered the following:

(Amendment Bar Code: 233951)

Amendment 12—Between lines 767 and 768, insert:
If no provider service network submits a responsive bid, the agency shall procure no more than one less than the maximum number of qualified plans permitted in that region. Within 12 months after the initial invitation to negotiate, the agency shall attempt to procure a qualified plan that is a provider service network. The agency shall notice another invitation to negotiate only with provider service networks in such region where no provider service network has been selected.

Rep. Fitzgerald moved the adoption of the amendment, which was adopted.

On motion by Rep. Chestnut, by the required two-thirds vote, the House agreed to consider the following late-filed amendment.

Representative Chestnut offered the following:

(Amendment Bar Code: 978065)

Amendment 13—Remove lines 814-818 and insert:
(c) Plans that spend more than 92 percent of Medicaid premium revenue shall be evaluated by the agency to determine whether higher expenditures are the result of failures in care management.
(d) Plans that spend 95 percent or more of Medicaid premium revenue and are determined to be failing to appropriately manage care shall be excluded from automatic enrollments.

Rep. Chestnut moved the adoption of the amendment, which was adopted.

On motion by Rep. Fitzgerald, by the required two-thirds vote, the House agreed to consider the following late-filed amendment.

Representative Brisé offered the following:

(Amendment Bar Code: 893659)

Amendment 14—Remove line 830 and insert:
network for failure to meet quality or performance criteria. If the plan excludes a provider from the plan, the plan must provide written notice to all recipients who have chosen that provider for care. The notice shall be provided at least 30 days prior to the effective date of the exclusion.

Rep. Fitzgerald moved the adoption of the amendment, which was adopted.

Representative Grimsley offered the following:

(Amendment Bar Code: 793097)

Amendment 15—Remove lines 847-854 and insert:
The hospitals described in paragraphs (a)-(d) shall make adequate arrangements for medical staff sufficient to fulfill their contractual obligations with the plans.

Rep. Grimsley moved the adoption of the amendment, which was adopted.

On motion by Rep. Jones, by the required two-thirds vote, the House agreed to consider the following late-filed amendment.

Representative Jones offered the following:

(Amendment Bar Code: 400337)

Amendment 16—Remove line 870 and insert:
screening rate of at least 80 percent of those recipients

Rep. Jones moved the adoption of the amendment, which was adopted.

The absence of a quorum was suggested. A quorum was present [Session Vote Sequence: 786].

On motion by Rep. Homan, by the required two-thirds vote, the House agreed to consider the following late-filed amendment.

Representative Homan offered the following:

(Amendment Bar Code: 573241)

Amendment 17—Remove lines 875-879 and insert:
to hospitals shall not exceed 150 percent of the rate the agency would have paid on the first day of the contract between the provider and the plan, unless specifically approved by the agency. Payment rates may be updated periodically.

Rep. Homan moved the adoption of the amendment, which was adopted.

On motion by Rep. Chestnut, by the required two-thirds vote, the House agreed to consider the following late-filed amendment.

Representatives Grimsley, Chestnut and Jones offered the following:

(Amendment Bar Code: 520401)

Amendment 18 (with title amendment)—Remove lines 880-894 and insert:
(8) CONFLICT RESOLUTION.—In order to protect the continued statewide operation of the Medicaid managed care program, the Medicaid Resolution Board is established to resolve disputes between managed care plans and hospitals and between managed care plans and the medical staff of the providers listed in s. 409.975(3)(a)-(d). The board shall consist of two members appointed by the Speaker of the House of Representatives, two members appointed by the President of the Senate, and three members appointed by the Governor. The costs of the board's activities to review and resolve disputes shall be shared equally by the parties to the dispute. Any managed care plan or above-named provider may initiate a review by the board for any conflict related to payment rates, contract terms, or other conditions. The board shall make recommendations to the agency regarding payment rates, procedures, or other contract terms to resolve such conflicts. The agency may amend the terms of the contracts with the parties to ensure compliance with these recommendations. This process shall not be used to review and reverse any managed care plan decision to exclude any provider that fails to meet quality standards.

T I T L E A M E N D M E N T

Remove line 85 and insert:
conflict resolution procedures; establishing the Medicaid Resolution Board for specified purposes; establishing plan

Rep. Chestnut moved the adoption of the amendment, which was adopted.

On motion by Rep. Jones, by the required two-thirds vote, the House agreed to consider the following late-filed amendment.

Representative Jones offered the following:

(Amendment Bar Code: 647097)

Amendment 19—Remove line 904 and insert:
provide a grace period of at least 120 days before disenrolling

Rep. Jones moved the adoption of the amendment, which was adopted.

On motion by Rep. Kreegel, by the required two-thirds vote, the House agreed to consider the following late-filed amendment.

Representatives Kreegel, Chestnut, Brisé and Jones offered the following:

(Amendment Bar Code: 880361)

Amendment 20—Remove line 941 and insert:
access to care by the providers described in this subsection. The amount paid to the plans to make supplemental payments or to enhance provider rates pursuant to this subsection shall be reconciled to the exact amounts the plans are required to pay to providers. The plans shall make the designated payments to providers within 15 business days of notification by the agency regarding provider-specific distributions.

Rep. Kreegel moved the adoption of the amendment, which was adopted.

On motion by Rep. Jones, by the required two-thirds vote, the House agreed to consider the following late-filed amendment.

Representative Jones offered the following:

(Amendment Bar Code: 753967)

Amendment 21—Remove lines 960-973 and insert:
standards. When a specialty plan is available to accommodate a specific condition or diagnosis of a recipient, the agency shall assign the recipient to that plan. The agency may not engage in practices that are designed to favor one managed care plan over another. When automatically enrolling recipients in plans, the agency shall automatically enroll based on the following criteria:
(a) Whether the plan has sufficient network capacity to meet the needs of the recipients.
(b) Whether the recipient has previously received services from one of the plan's primary care providers.
(c) Whether primary care providers in one plan are more geographically accessible to the recipient's residence than those in other plans.

Rep. Jones moved the adoption of the amendment, which was adopted.

Representative Schwartz offered the following:

(Amendment Bar Code: 591297)

Amendment 22 (with title amendment)—Remove lines 987-1361

T I T L E A M E N D M E N T

Remove lines 94-139 and insert:
opportunities for recipients; creating s. 409.986, F.S.;

Rep. Schwartz moved the adoption of the amendment.

The absence of a quorum was suggested. A quorum was present [Session Vote Sequence: 787].

The question recurred on the adoption of **Amendment 22**, which failed of adoption.

Representative Pafford offered the following:

(Amendment Bar Code: 612241)

Amendment 23—Remove lines 994-997 and insert:
Affairs and other state agencies. By July 1, 2012, the agency shall begin implementation of the statewide long-term care managed care program, with full implementation in all regions by October 1, 2014.

Rep. Pafford moved the adoption of the amendment, which failed of adoption.

On motion by Rep. Fitzgerald, by the required two-thirds vote, the House agreed to consider the following late-filed amendment.

Representative Fitzgerald offered the following:

(Amendment Bar Code: 785819)

Amendment 24—Between lines 1102 and 1103, insert:
If no provider service network submits a responsive bid, the agency shall procure one less qualified plan in each of the regions. Within 12 months after the initial invitation to negotiate, the agency shall attempt to procure a qualified plan that is a provider service network. The agency shall notice another invitation to negotiate only with provider service networks in such region where no provider service network has been selected.

Rep. Fitzgerald moved the adoption of the amendment, which was adopted.

On motion by Rep. Chestnut, by the required two-thirds vote, the House agreed to consider the following late-filed amendment.

Representative Chestnut offered the following:

(Amendment Bar Code: 544071)

Amendment 25—Remove lines 1168-1173 and insert:
(c) Plans that spend more than 92 percent of Medicaid premium revenue on long-term care services, including direct care management as determined by the agency, shall be evaluated by the agency to determine whether higher expenditures are the result of failures in care management.
(d) Plans that spend 95 percent or more of Medicaid premium revenue on long-term care services, including direct care management as determined by the agency, and are determined to be failing to appropriately manage care shall be excluded from automatic enrollments.

Rep. Chestnut moved the adoption of the amendment, which was adopted.

Representatives Grimsley and Chestnut offered the following:

(Amendment Bar Code: 712231)

Amendment 26—Remove line 1268 and insert:
community-based services shall be at least a 3 percent, up to a 5 percent, annual

Rep. Chestnut moved the adoption of the amendment, which was adopted.

Representative Grimsley offered the following:

(Amendment Bar Code: 733217)

Amendment 27—Remove lines 1427-1478 and insert:
disabilities become available in the recipient's region or the recipient has been offered enrollment in a developmental disabilities comprehensive long-term care plan or developmental disabilities long-term care plan.
(2) Unless specifically exempted, all eligible persons must be enrolled in a developmental disabilities comprehensive long-term care plan or a developmental disabilities long-term care plan. Medicaid recipients who are residents of a developmental disability center, including Sunland Center in Marianna and Tacachale Center in Gainesville, are exempt from mandatory enrollment but may voluntarily enroll in a long-term care plan.
Section 29. Section 409.988, Florida Statutes, is created to read:
409.988 Benefits.-Managed care plans shall cover, at a minimum, the services in this section. Plans may customize benefit packages or offer additional benefits to meet the needs of enrollees in the plan.
(1) Intermediate care for the developmentally disabled.
(2) Alternative residential services, including, but not limited to:
(a) Group homes and foster care homes licensed pursuant to chapters 393 and 409.
(b) Comprehensive transitional education programs licensed pursuant to chapter 393.
(c) Residential habilitation centers licensed pursuant to chapter 393.
(d) Assisted living facilities, and transitional living facilities licensed pursuant to chapters 400 and 429.
(3) Adult day training.
(4) Behavior analysis services.
(5) Companion services.
(6) Consumable medical supplies.
(7) Durable medical equipment and supplies.
(8) Environmental accessibility adaptations.
(9) In-home support services.
(10) Therapies, including occupational, speech, respiratory, and physical therapy.
(11) Personal care assistance.
(12) Residential habilitation services.
(13) Intensive behavioral residential habilitation services.
(14) Behavior focus residential habilitation services.
(15) Residential nursing services.
(16) Respite care.
(17) Case management.
(18) Supported employment.
(19) Supported living coaching.
(20) Transportation.
Section 30. Section 409.989, Florida Statutes, is created to read:
409.989 Qualified plans.—
(1) QUALIFIED PLANS.—Qualified plans that are a provider service network or the Children's Medical Services Network authorized under chapter 391 may be either developmental disabilities long-term care plans that cover benefits pursuant to s. 409.988, or developmental disabilities comprehensive long- term care plans that cover benefits pursuant to ss. 409.973 and 409.988. Other qualified plans may only be developmental disabilities comprehensive long-term care plans that cover benefits pursuant to ss. 409.973 and 409.988.

Rep. Aubuchon moved the adoption of the amendment, which was adopted.

On motion by Rep. Fitzgerald, by the required two-thirds vote, the House agreed to consider the following late-filed amendment.

Representative Fitzgerald offered the following:

(Amendment Bar Code: 637061)

Amendment 28—Between lines 1505 and 1506, insert:
If no provider service network submits a responsive bid, the agency shall procure no more than one less than the maximum number of qualified plans permitted in that region. Within 12 months after the initial invitation to negotiate, the agency shall attempt to procure a qualified plan that is a provider service network. The agency shall notice another invitation to negotiate only with provider service networks in such region where no provider service network has been selected.

Rep. Fitzgerald moved the adoption of the amendment, which was adopted.

On motion by Rep. Aubuchon, by the required two-thirds vote, the House agreed to consider the following late-filed amendment.

Representatives Aubuchon and Chestnut offered the following:

(Amendment Bar Code: 465831)

Amendment 29—Remove lines 1564-1576 and insert:

amount between actual spending and 92 percent of the Medicaid premium revenue.

(b) Plans that spend less than 92 percent of Medicaid premium revenue on long-term care services, including direct care management as determined by the agency shall be required to pay back the amount between actual spending and 92 percent of the Medicaid premium revenue.

Rep. Aubuchon moved the adoption of the amendment, which was adopted.

On motion by Rep. Jenne, by the required two-thirds vote, the House agreed to consider the following late-filed amendment.

Representative Brisé offered the following:

(Amendment Bar Code: 015355)

Amendment 30—Remove line 1589 and insert:
network for failure to meet quality or performance criteria. If the plan excludes a provider from the plan, the plan must provide written notice to all recipients who have chosen that provider for care. The notice shall be issued at least 90 days before the effective date of the exclusion.

Rep. Jenne moved the adoption of the amendment, which was adopted.

Representative Grimsley offered the following:

(Amendment Bar Code: 200861)

Amendment 31 (with title amendment)—Remove lines 1664-1670 and insert:

(6) The agency shall establish intensive behavior residential habilitation rates for providers approved by the agency to provide this service. The agency shall also establish intermediate care facility for the developmentally disabled-specific payment rates for each licensed intermediate care facility based on facility costs adjusted for inflation and other factors. Payments to intermediate care facilities for the developmentally disabled and providers of intensive behavior residential habilitation service shall be reconciled to reimburse the plan's actual payments to the facilities.

T I T L E A M E N D M E N T

Remove line 155 and insert:
intensive behavior residential habilitation providers and intermediate care facilities for the developmentally

Rep. Aubuchon moved the adoption of the amendment, which was adopted.

The absence of a quorum was suggested. A quorum was present [Session Vote Sequence: 788].

Representative Schwartz offered the following:

(Amendment Bar Code: 355159)

Amendment 32 (with title amendment)—Between lines 1696 and 1697, insert:

Section 34. Short title.—Sections 35 and 36 of this act may be cited as the "Independence at Home Act of 2010."

Section 35. Legislative findings.—The Legislature finds that:

(1) Unless changes are made to the way health care is delivered, growing demand for resources caused by rising health care costs and to a lesser extent the nation's expanding elderly and chronically ill population will confront Floridians with increasingly difficult choices between health care and other priorities. However, opportunities exist to constrain health care costs without adverse health care consequences.

(2) Medicaid beneficiaries with multiple chronic conditions account for a disproportionate share of Medicaid spending compared to their representation in the overall Medicaid population, and evidence suggests that such patients often receive poorly coordinated care, including conflicting information from health providers and different diagnoses of the same symptoms.

(3) People with chronic conditions account for 76 percent of all hospital admissions, 88 percent of all prescriptions filled, and 72 percent of physician visits.

(4) Studies show that hospital utilization and emergency room visits for patients with multiple chronic conditions can be reduced and significant savings can be achieved through the use of interdisciplinary teams of health care professionals caring for patients in their places of residence.

(5) The Independence at Home Act creates a chronic care coordination pilot project to bring primary care medical services to the highest cost Medicaid beneficiaries with multiple chronic conditions in their home or place of residence so that they may be as independent as possible for as long as possible in a comfortable setting.

(6) The Independence at Home Act generates savings by providing better, more coordinated care across all treatment settings to the highest cost Medicaid beneficiaries with multiple chronic conditions, reducing duplicative and unnecessary services, and avoiding unnecessary hospitalizations, nursing home admissions, and emergency room visits.

(7) The Independence at Home Act holds providers accountable for improving beneficiary outcomes, ensuring patient and caregiver satisfaction, and achieving cost savings to Medicaid on an annual basis.

(8) The Independence at Home Act creates incentives for practitioners and providers to develop methods and technologies for providing better and lower cost health care to the highest cost Medicaid beneficiaries with the greatest incentives provided in the case of highest cost beneficiaries.

(9) The Independence at Home Act contains the central elements of proven home-based primary care delivery models that have been utilized for years by the United States Department of Veterans Affairs and their "house calls" programs across the country to deliver coordinated care for chronic conditions in the comfort of a patient's home or place of residence.

Section 36. Independence at Home Chronic Care Coordination Pilot Project.—

(1) The Agency for Health Care Administration shall provide for the phased in development, implementation, and evaluation of Independence at Home programs described in this section to meet the following objectives:

(a) To improve patient outcomes, compared to comparable beneficiaries who do not participate in such a program, through reduced hospitalizations, nursing home admissions, or emergency room visits, increased symptom self-management, and similar results.

(b) To improve satisfaction of patients and caregivers, as demonstrated through a quantitative pretest and posttest survey developed by the agency that measures patient and caregiver satisfaction of care coordination, educational information, timeliness of response, and similar care features.

(c) To achieve a minimum of 5 percent in cost savings in the care of beneficiaries under this section who suffer from multiple high-cost chronic diseases.

(2) INITIAL IMPLEMENTATION; PHASE I.—

(a) IN GENERAL.—In carrying out this section and to the extent possible, the Agency for health Care Administration shall enter into agreements with at least two unaffiliated Independence-at-Home organizations in each of the counties in the state to provide chronic care coordination services for a period of 3 years or until those agreements are terminated by the agency. Agreements under this paragraph shall continue in effect until the agency makes a determination pursuant to subsection (3) or until those agreements are supplanted by new agreements entered into under that section. The phase of implementation under this paragraph shall be known as the initial implementation phase or phase I.

(b) PREFERENCE.—In selecting Independence at Home organizations under this paragraph, the agency shall give a preference, to the extent practicable, to organizations that:

1. Have documented experience in furnishing the types of services covered under this section to eligible beneficiaries in their home or place of residence using qualified teams of health care professionals who are under the direction

of a qualified Independence at Home physician or, in a case when such direction is provided by an Independence at Home physician to a physician assistant who has at least 1 year of experience providing medical and related services for chronically ill individuals in their homes, or other similar qualification as determined by the agency to be appropriate for the Independence at Home program, by the physician assistant acting under the supervision of an Independence at Home physician and as permitted under state law, or by an Independence at Home nurse practitioner;

2. Have the capacity to provide services covered by this section to at least 150 eligible beneficiaries; and

3. Use electronic medical records, health information technology, and individualized plans of care.

(3) EXPANDED IMPLEMENTATION PHASE; PHASE II.—

(a) IN GENERAL.—For periods beginning after the end of the 3-year initial implementation period under subsection (2), and subject to paragraph (b), the Agency For Health Care Administration shall renew agreements described in subsection (2) with an Independence at Home organization that has met all the objectives specified in subsection (1) and enter into agreements described in subsection (2) with any other organization that is located in the state that was not an Independence at Home organization during the initial implementation period and that meets the qualifications of an Independence at Home organization under this section. The agency may terminate and not renew such an agreement with an organization that has not met such objectives during the initial implementation period. The phase of implementation under this paragraph shall be known as the expanded implementation phase or phase II.

(b) CONTINGENCY.—The expanded implementation under paragraph (a) may not occur if the agency finds, not later than 60 days after the date of issuance of the independent evaluation under subsection (5) that continuation of the Independence at Home project is not in the best interest of beneficiaries under this section.

(4) ELIGIBILITY.—An organization is not prohibited from participating under this section during expanded implementation phase under subsection (3) and, to the extent practicable, during initial implementation phase under subsection (2) because of its small size as long as it meets the eligibility requirements of this section.

(5) INDEPENDENT EVALUATIONS.—

(a) IN GENERAL.—The agency shall contract for an independent evaluation of the initial implementation phase under subsection (2) with an interim report to the Legislature to be provided on such evaluation as soon as practicable after the first year of such phase and a final report to be provided to the Legislature as soon as practicable following the conclusion of the initial implementation phase, but not later than 6 months following the end of such phase. Such an evaluation shall be conducted by individuals with knowledge of chronic care coordination programs for the targeted patient population and demonstrated experience in the evaluation of such programs.

(b) INFORMATION TO BE INCLUDED.—Each report shall include an assessment of the following factors and shall identify the characteristics of individual Independence at Home programs that are the most effective in producing improvements in:

1. Beneficiary, caregiver, and provider satisfaction;

2. Health outcomes appropriate for patients with multiple chronic diseases; and

3. Cost savings to the program under this title, such as in reducing:

a. Hospital and skilled nursing facility admission rates and lengths of stay;

b. Hospital readmission rates; and

c. Emergency department visits.

(c) BREAKDOWN BY CONDITION.—Each such report shall include data on performance of Independence-at-Home organizations in responding to the needs of eligible beneficiaries with specific chronic conditions and combinations of conditions, as well as the overall eligible beneficiary population.

(6) AGREEMENTS.—

(a) IN GENERAL.—The agency shall enter into agreements, beginning not later than one year after the date of the enactment of this section, with Independence at Home organizations that meet the participation requirements of this section, including minimum performance standards developed under subsection (e)(3), in order to provide access by eligible beneficiaries to Independence at Home programs under this section.

(b) AUTHORITY.—If the agency deems it necessary to serve the best interest of the beneficiaries under this title the agency may:

1. Require screening of all potential Independence at Home organizations, including owners, (such as through fingerprinting, licensure checks, site-visits, and other database checks) before entering into an agreement;

2. Require a provisional period during which a new Independence at Home organization would be subject to enhanced oversight (such as prepayment review, unannounced site visits, and payment caps); and

3. Require applicants to disclose previous affiliation with entities that have uncollected Medicaid debt, and authorize the denial of enrollment if the agency determines that these affiliations pose undue risk to the program.

(7) REGULATIONS.—At least three months before entering into the first agreement under this section, the agency shall publish in the Florida Code the specifications for implementing this section. Such specifications shall describe the implementation process from initial to final implementation phases, including how the agency will identify and notify potential enrollees and how and when beneficiaries may enroll and disenroll from Independence at Home programs and change the programs in which they are enrolled.

(8) PERIODIC PROGRESS REPORTS.—Semi-annually during the first year in which this section is implemented and annually thereafter during the period of implementation of this section, the agency shall submit to the appropriate Committees of the House and Senate a report that describes the progress of implementation of this section and explaining any variation from the Independence at Home program as described in this section.

(9) ANNUAL BEST PRACTICES CONFERENCE.—During the initial implementation phase and to the extent practicable at intervals thereafter, the agency shall provide for an annual Independence at Home teleconference for Independence at Home organizations to share best practices and review treatment interventions and protocols that were successful in meeting all 3 objectives specified in paragraph (1).

(b) Definitions.—For purposes of this section:

(1) ACTIVITIES OF DAILY LIVING.—The term `activities of daily living' means bathing, dressing, grooming, transferring, feeding, or toileting.

(2) CAREGIVER.—The term "caregiver" means, with respect to an individual with a qualifying functional impairment, a family member, friend, or neighbor who provides assistance to the individual.

(3) ELIGIBLE BENEFICIARY.—

(a) IN GENERAL.—The term `eligible beneficiary' means, with respect to an Independence at Home program, an individual who:

1. Is entitled to benefits under Florida's Medicaid program;

2. Has a qualifying functional impairment and has been diagnosed with two or more of the chronic conditions described in subparagraph (C); and

3. Within the 12 months prior to the individual first enrolling with an Independence at Home program under this section, has received benefits under part A for the following services:

(I) Non-elective inpatient hospital services.

(II) Services in the emergency department of a hospital.

(III) Any one of the following:

(aa) Skilled nursing or sub-acute rehabilitation services in a Medicaid-certified nursing facility.

(bb) Comprehensive acute rehabilitation facility or Comprehensive outpatient rehabilitation facility services.

(cc) Skilled nursing or rehabilitation services through a Medicaid-certified home health agency.

(b) DISQUALIFICATIONS.—Such term does not include an individual:

1. Who resides in a setting that presents a danger to the safety of in-home health care providers and primary caregivers; or

2. Whose enrollment in an Independence at Home program the agency determines would be inappropriate.

(C) CHRONIC CONDITIONS DESCRIBED.—The chronic conditions described in this subparagraph are the following:

1. Congestive heart failure.

2. Diabetes.

3. Chronic obstructive pulmonary disease.

4. Ischemic heart disease.

5. Peripheral arterial disease.

6. Stroke.

7. Alzheimer's Disease and other dementias designated by the agency.

8. Pressure ulcers.

9. Hypertension.

10. Myasthenia Graves

11. Neurodegenerative diseases designated by the agency which result in high costs under this title, including amyotrophic lateral sclerosis (ALS), multiple sclerosis, and Parkinson's disease.

12. Any other chronic condition that the agency identifies as likely to result in high costs to the program under this title when such condition is present in combination with one or more of the chronic conditions specified in the preceding clauses.

(4) INDEPENDENCE AT HOME ASSESSMENT.—The term "Independence-at-Home assessment" means a determination of eligibility of an individual for an Independence at Home program as an eligible beneficiary as defined in paragraph (3), a comprehensive medical history, physical examination, and assessment of the beneficiary's clinical and functional status that:

(a) Is conducted in person by an individual—

1. Who—

a. is an Independence at Home physician or an Independence at Home nurse practitioner; or

b. A physician assistant, nurse practitioner, or clinical nurse specialist who is employed by an Independence at Home organization and is supervised by an Independence at Home physician or Independence at Home nurse practitioner; and

(ii) Does not have an ownership interest in the Independence at Home organization unless the agency determines that it is impracticable to preclude such individual's involvement; and

(b) Includes an assessment of—

1. Activities of daily living and other co-morbidities;

2. Medications and medication adherence;

3. Affect, cognition, executive function, and presence of mental disorders;

4. Functional status, including mobility, balance, gait, risk of falling, and sensory function;

5. social functioning and social integration;

6. Environmental needs and a safety assessment;

7. The ability of the beneficiary's primary caregiver to assist with the beneficiary's care as well as the caregiver's own physical and emotional capacity, education, and training;

8. Whether, in the professional judgment of the individual conducting the assessment, the beneficiary is likely to benefit from an Independence at Home program;

9. Whether the conditions in the beneficiary's home or place of residence would permit the safe provision of services in the home or residence, respectively, under an Independence at Home program;

10. Whether the beneficiary has a designated primary care physician whom the beneficiary has seen in an office-based setting within the previous 12 months; and

11. Other factors determined appropriate by the agency.

(5) INDEPENDENCE AT HOME CARE TEAM.—The term "Independence-at-Home care team".—

(a) Means, with respect to a participant, a team of qualified individuals that provides services to the participant as part of an Independence at Home program; and

(b) Includes an Independence at Home physician and/or an Independence at Home nurse practitioner and an Independence at Home coordinator (who may also be an Independence at Home physician or an Independence at Home nurse practitioner).

(6) INDEPENDENCE AT HOME COORDINATOR.—The term "Independence-at-Home coordinator" means, with respect to a participant, an individual who—

(a) Is employed by an Independence at Home organization and is responsible for coordinating all of the services of the participant's Independence at Home plan;

(b) Is a licensed health professional, such as a physician, registered nurse, nurse practitioner, clinical nurse specialist, physician assistant, or other health care professional as the agency determines appropriate, who has at least one year of experience providing and coordinating medical and related services for individuals in their homes; and

(c) Serves as the primary point of contact responsible for communications with the participant and for facilitating communications with other health care providers under the plan.

(7) INDEPENDENCE AT HOME ORGANIZATION.—The term "Independence-at-Home organization" means a provider of services, a physician or physician group practice which receives payment for services furnished under this title (other than only under this section) and which—

(a) Has entered into an agreement under subsection (a)(2) to provide an Independence at Home program under this section;

(b)1. Provides all of the services of the Independence at Home plan in a participant's home or place of residence, or

2. If the organization is not able to provide all such services in such home or residence, has adequate mechanisms for ensuring the provision of such services by one or more qualified entities;

(c) Has Independence at Home physicians, clinical nurse specialists, nurse practitioners, or physician assistants available to respond to patient emergencies 24 hours a day, seven days a week;

(d) Accepts all eligible beneficiaries from the organization's service area, as determined under the agreement with the agency under this section, except to the extent that qualified staff are not available; and

(e) Meets other requirements for such an organization under this section.

(8) INDEPENDENCE AT HOME PHYSICIAN.—The term "Independence-at-Home physician" means a physician who:

(a) Is employed by or affiliated with an Independence at Home organization, as required under paragraph (7)(C), or has another contractual relationship with the Independence at Home organization that requires the physician to make in-home visits and to be responsible for the plans of care for the physician's patients;

(b) Is certified—

1. By the American Board of Family Physicians, the American Board of Internal Medicine, the American Osteopathic Board of Family Physicians, the American Osteopathic Board of Internal Medicine, the American Board of Emergency Medicine, or the American Board of Physical Medicine and Rehabilitation; or

2. By a Board recognized by the American Board of Medical Specialties and determined by the agency to be appropriate for the Independence at Home program;

(c) Has—

1. A certification in geriatric medicine as provided by American Board of Medical Specialties; or

2. Passed the clinical competency examination of the American Academy of Home Care Physicians and has substantial experience in the delivery of medical care in the home, including at least two years of experience in the management of Medicare or Medicaid patients and one year of experience in home-based medical care including at least 200 house calls; and

(d) Has furnished services during the previous 12 months for which payment is made under this title.

(9) INDEPENDENCE AT HOME NURSE PRACTITIONER.—The term "Independence-at-Home nurse practitioner" means a nurse practitioner who:

(a) Is employed by or affiliated with an Independence at Home organization, as required under paragraph (7)(C), or has another contractual relationship with the Independence at Home organization that requires the nurse practitioner to make in-home visits and to be responsible for the plans of care for the nurse practitioner's patients;

(b) Practices in accordance with State law regarding scope of practice for nurse practitioners;

(c) Is certified—

1. As a Gerontologic Nurse Practitioner by the American Academy of Nurse Practitioners Certification Program or the American Nurses Credentialing Center; or

2. As a family nurse practitioner or adult nurse practitioner by the American Academy of Nurse Practitioners Certification Board or the

American Nurses Credentialing Center and holds a certificate of Added Qualification in gerontology, elder care or care of the older adult provided by the American Academy of Nurse Practitioners, the American Nurses Credentialing Center or a national nurse practitioner certification board deemed by the agency to be appropriate for an Independence at Home program; and

(d) has furnished services during the previous 12 months for which payment is made under this title.

(10) INDEPENDENCE-AT-HOME PLAN-The term "Independence at Home plan" means a plan established under subsection (d)(2) for a specific participant in an Independence at Home program.

(11) INDEPENDENCE-AT-HOME PROGRAM-The term "Independence-at-Home program" means a program described in subsection (d) that is operated by an Independence at Home organization.

(12) PARTICIPANT.—The term "participant" means an eligible beneficiary who has voluntarily enrolled in an Independence at Home program.

(13) QUALIFIED ENTITY.—The term "qualified entity" means a person or organization that is licensed or otherwise legally permitted to provide the specific service (or services) provided under an Independence at Home plan that the entity has agreed to provide.

(14) QUALIFYING FUNCTIONAL IMPAIRMENT.—The term "qualifying functional impairment" means an inability to perform, without the assistance of another person, three (3) or more activities of daily living.

(15) QUALIFIED INDIVIDUAL.—The term "qualified individual" means an individual that is licensed or otherwise legally permitted to provide the specific service (or services) under an Independence at Home plan that the individual has agreed to provide.

(c) Identification and Enrollment of Prospective Program Participants.—

(1) NOTICE TO ELIGIBLE INDEPENDENCE AT HOME BENEFICIARIES- the agency shall develop a model notice to be made available to Medicaid beneficiaries (and to their caregivers) who are potentially eligible for an Independence at Home program by participating providers and by Independence at Home programs. Such notice shall include the following information:

(a) A description of the potential advantages to the beneficiary participating in an Independence at Home program.

(b) A description of the eligibility requirements to participate.

(c) Notice that participation is voluntary.

(d) A statement that all other Medicaid benefits remain available to beneficiaries who enroll in an Independence at Home program.

(e) Notice that those who enroll in an Independence at Home program will be responsible for copayments for house calls made by Independence at Home physicians, physician assistants, or by Independence at Home nurse practitioners, except that such copayments may be reduced or eliminated at the discretion of the Independence at Home physician, physician assistant, or Independence at Home nurse practitioner involved in accordance with paragraph (f).

(f) A description of the services that could be provided.

(g) A description of the method for participating, or withdrawing from participation, in an Independence at Home program or becoming no longer eligible to so participate.

(2) VOLUNTARY PARTICIPATION AND CHOICE- An eligible beneficiary may participate in an Independence at Home program through enrollment in such program on a voluntary basis and may terminate such participation at any time. Such a beneficiary may also receive Independence at Home services from the Independence at Home organization of the beneficiary's choice but may not receive Independence at Home services from more than one Independence at Home organization at a time.

(d) Independence at Home Program Requirements-

(1) IN GENERAL- Each Independence at Home program shall, for each participant enrolled in the program—

(a) Designate—

1. An Independence at Home physician or an Independence at Home nurse practitioner; and

2. An Independence at Home coordinator;

(b) Have a process to ensure that the participant received an Independence at Home assessment before enrollment in the program;

(c) With the participation of the participant (or the participant's representative or caregiver), an Independence at Home physician, a physician assistant under the supervision of an Independence at Home physician and as permitted under State law, or an Independence at Home nurse practitioner, and the Independence at Home coordinator, develop an Independence at Home plan for the participant in accordance with paragraph (2);

(d) Ensure that the participant receives an Independence at Home assessment at least every 6 months after the original assessment to ensure that the Independence at Home plan for the participant remains current and appropriate;

(e) Implement all of the services under the participant's Independence at Home plan and in instances in which the Independence at Home organization does not provide specific services within the Independence at Home plan, ensure that qualified entities successfully provide those specific services; and

(f) Provide for an electronic medical record and electronic health information technology to coordinate the participant's care and to exchange information with the Medicaid program and electronic monitoring and communication technologies and mobile diagnostic and therapeutic technologies as appropriate and accepted by the participant.

(2) INDEPENDENCE AT HOME PLAN.—

(a) IN GENERAL.—An Independence at Home plan for a participant shall be developed with the participant, an Independence at Home physician, a physician assistant under the supervision of an Independence at Home physician and as permitted under State law, an Independence at Home nurse practitioner, or an Independence at Home coordinator, and, if appropriate, one or more of the participant's caregivers and shall:

1. Document the chronic conditions, co-morbidities, and other health needs identified in the participant's Independence at Home assessment;

2. Determine which services under an Independence at Home plan described in subparagraph (C) are appropriate for the participant; and

3. Identify the qualified entity responsible for providing each service under such plan.

(b) COMMUNICATION OF INDIVIDUALIZED INDEPENDENCE AT HOME PLAN TO THE INDEPENDENCE AT HOME COORDINATOR.—If the individual responsible for conducting the participant's Independence at Home assessment and developing the Independence at Home plan is not the participant's Independence at Home coordinator, the Independence at Home physician or Independence at Home nurse practitioner is responsible for ensuring that the participant's Independence at Home coordinator has such plan and is familiar with the requirements of the plan and has the appropriate contact information for all of the members of the Independence at Home care team.

(c) SERVICES PROVIDED UNDER AN INDEPENDENCE AT HOME PLAN.—An Independence-at-Home organization shall coordinate and make available through referral to a qualified entity the services described in the following clauses (i) through (iii) to the extent they are needed and covered by under this title and shall provide the care coordination services described in the following clause (iv) to the extent they are appropriate and accepted by a participant:

1. Primary care services, such as physician visits, diagnosis, treatment, and preventive services.

2. Home health services, such as skilled nursing care and physical and occupational therapy.

3. Phlebotomy and ancillary laboratory and imaging services, including point of care laboratory and imaging diagnostics.

4. Care coordination services, consisting of—

(I) Monitoring and management of medications by a pharmacist who is certified in geriatric pharmacy by the Commission for Certification in Geriatric Pharmacy or possesses other comparable certification demonstrating knowledge and expertise in geriatric or chronic disease pharmacotherapy , as well as assistance to participants and their caregivers with respect to selection of a prescription drug plan that best meets the needs of the participant's chronic conditions.

(II) Coordination of all medical treatment furnished to the participant, regardless of whether such treatment is covered and available to the participant under this title.

(III) Self-care education and preventive care consistent with the participant's condition.

(IV) Education for primary caregivers and family members.

(V) Caregiver counseling services and information about, and referral to, other caregiver support and health care services in the community.

(VI) Referral to social services, such as personal care, meals, volunteers, and individual and family therapy.

(VII) Information about, and access to, hospice care.

(VIII) Pain and palliative care and end-of-life care, including information about developing advanced directives and physicians orders for life sustaining treatment.

(3) PRIMARY TREATMENT ROLE WITHIN AN INDEPENDENCE AT HOME CARE TEAM- An Independence at Home physician, a physician assistant under the supervision of an Independence at Home physician and as permitted under State law, or an Independence at Home nurse practitioner may assume the primary treatment role as permitted under State law.

(4) ADDITIONAL RESPONSIBILITIES-

(a) OUTCOMES REPORT- Each Independence at Home organization offering an Independence at Home program shall monitor and report to the agency, in a manner specified by AHCA, on:

1. Patient outcomes;

2. Beneficiary, caregiver, and provider satisfaction with respect to coordination of the participant's care; and

3. The achievement of mandatory minimum savings described in subsection (e)(6).

(b) ADDITIONAL REQUIREMENTS- Each such organization and program shall provide AHCA with listings of individuals employed by the organization, including contract employees, and individuals with an ownership interest in the organization and comply with such additional requirements as AHCA may specify.

(e) Terms and Conditions.-

(1) IN GENERAL- An agreement under this section with an Independence at Home organization shall contain such terms and conditions as AHCA may specify consistent with this section.

(2) CLINICAL, QUALITY IMPROVEMENT, AND FINANCIAL REQUIREMENTS-The agency may not enter into an agreement with such an organization under this section for the operation of an Independence at Home program unless—

(a) The program and organization meet the requirements of subsection (d), minimum quality and performance standards developed under paragraph (3), and such clinical, quality improvement, financial, program integrity, and other requirements as the agency deems to be appropriate for participants to be served; and

(b) The organization demonstrates to the satisfaction of the agency that the organization is able to assume financial risk for performance under the agreement with respect to payments made to the organization under such agreement through available reserves, reinsurance, or withholding of funding provided under this title, or such other means as AHCA determines appropriate.

(3) MINIMUM QUALITY AND PERFORMANCE STANDARDS-

(a) IN GENERAL-The agency shall develop mandatory minimum quality and performance standards for Independence at Home organizations and programs which shall be no more stringent that those established by the Federal Center for Medicare/Medicaid Services (CMS).

(b) STANDARDS TO BE INCLUDED- Such standards shall include measures of:

1. Improvement in participant outcomes;

2. Improvement in satisfaction of the beneficiary, caregiver, and provider involved; and

3. Cost savings consistent with paragraph (6).

(c) MINIMUM PARTICIPATION STANDARD.—Such standards shall include a requirement that, for any year after the first year and except as the agency may provide for a program serving a rural area, an Independence at Home program had an average number of participants during the previous year of at least 150 participants.

(4) TERM OF AGREEMENT AND MODIFICATION- The agreement under this subsection shall be, subject to paragraphs (3)(C) and (5), for a period of three years, and the terms and conditions may be modified during the contract period by the agency as necessary to serve the best interest of the beneficiaries under this title or the best interest of Federal health care programs or upon the request of the Independence at Home organization.

(5) TERMINATION AND NON-RENEWAL OF AGREEMENT.—

(a) IN GENERAL.—If AHCA determines that an Independence at Home organization has failed to meet the minimum performance standards under paragraph (3) or other requirements under this section, or if AHCA deems it necessary to serve the best interest of the beneficiaries under this title or the best interest of Federal health care programs, AHCA may terminate the agreement of the organization at the end of the contract year.

(b) REQUIRED TERMINATION WHERE RISK TO HEALTH OR SAFETY OF A PARTICIPANT.—The agency shall terminate an agreement with an Independence at Home organization at any time the agency determines that the care being provided by such organization poses a threat to the health and safety of a participant.

(c) TERMINATION BY INDEPENDENCE AT HOME ORGANIZATIONS.—Notwithstanding any other provision of this subsection, an Independence at Home organization may terminate an agreement with the agency under this section to provide an Independence at Home program at the end of a contract year if the organization provides to the agency and to the beneficiaries participating in the program notification of such termination more than 90 days before the end of such year. Paragraphs (6), (8), and (9)(B) shall apply to the organization until the date of termination.

(d) NOTICE OF INVOLUNTARY TERMINATION.—The agency shall notify the participants in an Independence at Home program as soon as practicable if a determination is made to terminate an agreement with the Independence at Home organization involuntarily as provided in paragraphs (a) and (b). Such notice shall inform the beneficiary of any other Independence at Home organizations that might be available to the beneficiary.

(6) MANDATORY MINIMUM SAVINGS-

(a) REQUIRED-

1. IN GENERAL.—Under an agreement under this subsection, each Independence at Home organization shall ensure that during any year of the agreement for its Independence at Home program, there is an aggregate savings in the cost to the program under this title for participating beneficiaries, as calculated under subparagraph (B), that is not less than 5 percent of the product described in clause (ii) for such participating beneficiaries and year.

2. PRODUCT DESCRIBED.—The product described in this clause for participating beneficiaries in an Independence at Home program for a year is the product of—

(I) The estimated average monthly costs that would have been incurred under Florida Medicaid , other than those in the Medicaid Reform Pilot Counties if those beneficiaries had not participated in the Independence at Home program; and

(II) The number of participant-months for that year.

(b) COMPUTATION OF AGGREGATE SAVINGS-

1. MODEL FOR CALCULATING SAVINGS.—The agency shall contract with a nongovernmental organization or academic institution to independently develop an analytical model for determining whether an Independence at Home program achieves at least savings required under paragraph (a) relative to costs that would have been incurred by Medicaid in the absence of Independence at Home programs. The analytical model developed by the independent research organization for making these determinations shall utilize state-of-the-art econometric techniques, such as Heckman's selection correction methodologies, to account for sample selection bias, omitted variable bias, or problems with endogeneity.

2. APPLICATION OF THE MODEL.—Using the model developed under clause (i), the agency shall compare the actual costs to Medicaid of beneficiaries participating in an Independence at Home program to the predicted costs to Medicaid of such beneficiaries to determine whether an

Independence at Home program achieves the savings required under subparagraph (A).

3. REVISIONS OF THE MODE.—The agency shall require that the model developed under clause (i) for determining savings shall be designed according to instructions that will control, or adjust for, inflation as well as risk factors including, age, race, gender, disability status, socioeconomic status, region of country (such as State, county, metropolitan statistical area, or zip code), and such other factors as the agency determines to be appropriate, including adjustment for prior health care utilization. the agency may add to, modify, or substitute for such adjustment factors if such changes will improve the sensitivity or specificity of the calculation of costs savings.

4. PARTICIPANT-MONTH.—In making the calculation described in subparagraph (a), each month or part of a month in a program year that a beneficiary participates in an Independence at Home program shall be counted as a "participant-month".

(c) NOTICE OF SAVINGS CALCULATION- No later than 30 days before the beginning of the first year of the pilot project under this section and 120 days before the beginning of any Independence at Home program year after the first such year, the agency shall publish in the Florida Administrative Weekly description of the model developed under subparagraph (B)(i) and information for calculating savings required under subparagraph (A), including any revisions, sufficient to permit Independence at Home organizations to determine the savings they will be required to achieve during the program year to meet the savings requirement under subparagraph (A). In order to facilitate this notice, the agency may designate a single annual date for the beginning of all Independence at Home program years that shall not be later than one year from the date of enactment of this section.

(7) MANNER OF PAYMENT.—Subject to paragraph (8), payments shall be made by the agency to an Independence at Home organization at a rate negotiated between the agency and the organization under the agreement for:

(a) Independence at Home assessments; and

(b) On a per-participant, per-month basis for the items and services required to be provided or made available under subsection (2).

(8) ENSURING MANDATORY MINIMUM SAVINGS-The agency shall require any Independence at Home organization that fails in any year to achieve the mandatory minimum savings described in subsection (6) to provide those savings by refunding payments made to the organization under paragraph (7) during such year.

(9) BUDGET NEUTRAL PAYMENT CONDITION-

(a) IN GENERAL- Under this section, the agency shall ensure that the cumulative, aggregate sum of Medicaid program benefit expenditures for participants in Independence at Home programs and funds paid to Independence at Home organizations under this section, shall not exceed the Medicaid program benefit expenditures under such parts that the agency estimates would have been made for such participants in the absence of such programs.

(b) TREATMENT OF SAVINGS-

1. INITIAL IMPLEMENTATION PHASE.—If an Independence at Home organization achieves aggregate savings in a year in the initial implementation phase in excess of the mandatory minimum savings described in paragraph (6)(A)(ii), 80 percent of such aggregate savings shall be paid to the organization and the remainder shall be retained by the programs under this title during the initial implementation phase.

2. EXPANDED IMPLEMENTATION PHASE- If an Independence at Home organization achieves aggregate savings in a year in the expanded implementation phase in excess of 5 percent of the product described in paragraph (6)(A)(ii)—

(I) Insofar as such savings do not exceed 25 percent of such product, 80 percent of such aggregate savings shall be paid to the organization and the remainder shall be retained by the programs under this title; and

(II) Insofar as such savings exceed 25 percent of such product, in the agency's discretion, 50 percent of such excess aggregate savings shall be paid to the organization and the remainder shall be retained by the programs under this title.

(f) Waiver of Coinsurance for House Calls.—A physician, physician assistant, or nurse practitioner furnishing services related to the Independence at Home program in the home or residence of a participant in an Independence at Home program may waive collection of any coinsurance that might otherwise be payable under section 1833(a) with respect to such services but only if the conditions described in section 1128A(i)(6)(A) are met.

(g) Report.—Not later than 3 months after the date of receipt of the independent evaluation provided under subsection (5) and each year thereafter during which this section is being implemented, the agency shall submit to the Committees of jurisdiction in Congress a report that shall include:

(1) Whether the Independence at Home programs under this section are meeting the minimum quality and performance standards in (e)(3);

(2) A comparative evaluation of Independence at Home organizations in order to identify which programs, and characteristics of those programs, were the most effective in producing the best participant outcomes, patient and caregiver satisfaction, and cost savings; and

(3) An evaluation of whether the participant eligibility criteria identified beneficiaries who were in the top ten percent of the highest cost Medicaid beneficiaries.

T I T L E A M E N D M E N T

Remove line 159 and insert:

recipients; providing a short title; creating the "Independence at Home Act"; providing legislative findings; providing for an Independence at Home Chronic Care pilot project; providing for implementation and independent evaluation of the pilot project; requiring a report to the United States Congress; providing an effective date.

Rep. Schwartz moved the adoption of the amendment, which failed of adoption.

Representative Pafford offered the following:

(Amendment Bar Code: 375887)

Amendment 33 (with title amendment)—Remove everything after the enacting clause and insert:

Section 1. Paragraph (k) is added to subsection (3) of section 409.907, Florida Statutes, and subsection (13) is added to that section, to read:

409.907 Medicaid provider agreements.—The agency may make payments for medical assistance and related services rendered to Medicaid recipients only to an individual or entity who has a provider agreement in effect with the agency, who is performing services or supplying goods in accordance with federal, state, and local law, and who agrees that no person shall, on the grounds of handicap, race, color, or national origin, or for any other reason, be subjected to discrimination under any program or activity for which the provider receives payment from the agency.

(3) The provider agreement developed by the agency, in addition to the requirements specified in subsections (1) and (2), shall require the provider to:

(k) Fully comply with the agency's Medicaid Encounter Data System.

(13) By January 1, 2011, and annually thereafter until full compliance is reached, the agency shall submit to the Governor, the President of the Senate, and the Speaker of the House of Representatives a report that summarizes data regarding the agency's Medicaid Encounter Data System, including the number of participating providers, the level of compliance of each provider, and an analysis of service utilization, service trends, and specific problem areas.

Section 2. Subsection (4) of section 409.908, Florida Statutes, is amended to read:

409.908 Reimbursement of Medicaid providers.—Subject to specific appropriations, the agency shall reimburse Medicaid providers, in accordance with state and federal law, according to methodologies set forth in the rules of the agency and in policy manuals and handbooks incorporated by reference therein. These methodologies may include fee schedules, reimbursement methods based on cost reporting, negotiated fees, competitive bidding pursuant to s. 287.057, and other mechanisms the agency considers efficient and effective for purchasing services or goods on behalf of recipients. If a

provider is reimbursed based on cost reporting and submits a cost report late and that cost report would have been used to set a lower reimbursement rate for a rate semester, then the provider's rate for that semester shall be retroactively calculated using the new cost report, and full payment at the recalculated rate shall be effected retroactively. Medicare-granted extensions for filing cost reports, if applicable, shall also apply to Medicaid cost reports. Payment for Medicaid compensable services made on behalf of Medicaid eligible persons is subject to the availability of moneys and any limitations or directions provided for in the General Appropriations Act or chapter 216. Further, nothing in this section shall be construed to prevent or limit the agency from adjusting fees, reimbursement rates, lengths of stay, number of visits, or number of services, or making any other adjustments necessary to comply with the availability of moneys and any limitations or directions provided for in the General Appropriations Act, provided the adjustment is consistent with legislative intent.

(4) Subject to any limitations or directions provided for in the General Appropriations Act, alternative health plans, health maintenance organizations, and prepaid health plans shall be reimbursed a fixed, prepaid amount negotiated, or competitively bid pursuant to s. 287.057, by the agency and prospectively paid to the provider monthly for each Medicaid recipient enrolled. The amount may not exceed the average amount the agency determines it would have paid, based on claims experience, for recipients in the same or similar category of eligibility. The agency shall calculate capitation rates on a regional basis and~~, beginning September 1, 1995,~~ shall include age-band differentials in such calculations.

(a) Beginning October 1, 2010, the agency shall begin a budget-neutral adjustment of capitation rates based on aggregate risk scores for each provider's enrollees. During the first 2 years of the adjustment, the agency shall ensure that no provider has an aggregate risk score that varies by more than 10 percent from the aggregate weighted average for all providers. The risk-adjusted capitation rates shall be phased in as follows:

1. In the first contract year, 75 percent of the capitation rate shall be based on the current methodology and 25 percent shall be based on the risk-adjusted capitation rate methodology.

2. In the second contract year, 50 percent of the capitation rate shall be based on the current methodology and 50 percent shall be based on the risk-adjusted capitation rate methodology.

3. In the third contract year, the risk-adjusted capitation rate methodology shall be fully implemented.

(b) The Secretary of Health Care Administration shall convene a technical advisory panel to advise the agency in the area of risk-adjusted rate setting during the transition to risk-adjusted capitation rates described in paragraph (a). The panel shall include representatives of prepaid plans in counties that are not included as demonstration sites under s. 409.91211(1). The panel shall advise the agency regarding:

1. The selection of a base year of encounter data to be used to set risk-adjusted capitation rates.

2. The completeness and accuracy of the encounter data set.

3. The effect of risk-adjusted capitation rates on prepaid plans based on a review of a simulated rate-setting process.

Section 3. Paragraphs (b) and (d) of subsection (4) of section 409.912, Florida Statutes, are amended, and subsection (54) is added to that section, to read:

409.912 Cost-effective purchasing of health care.—The agency shall purchase goods and services for Medicaid recipients in the most cost-effective manner consistent with the delivery of quality medical care. To ensure that medical services are effectively utilized, the agency may, in any case, require a confirmation or second physician's opinion of the correct diagnosis for purposes of authorizing future services under the Medicaid program. This section does not restrict access to emergency services or poststabilization care services as defined in 42 C.F.R. part 438.114. Such confirmation or second opinion shall be rendered in a manner approved by the agency. The agency shall maximize the use of prepaid per capita and prepaid aggregate fixed-sum basis services when appropriate and other alternative service delivery and reimbursement methodologies, including competitive bidding pursuant to s. 287.057, designed to facilitate the cost-effective purchase of a case-managed continuum of care. The agency shall also require providers to minimize the exposure of recipients to the need for acute inpatient, custodial, and other institutional care and the inappropriate or unnecessary use of high-cost services. The agency shall contract with a vendor to monitor and evaluate the clinical practice patterns of providers in order to identify trends that are outside the normal practice patterns of a provider's professional peers or the national guidelines of a provider's professional association. The vendor must be able to provide information and counseling to a provider whose practice patterns are outside the norms, in consultation with the agency, to improve patient care and reduce inappropriate utilization. The agency may mandate prior authorization, drug therapy management, or disease management participation for certain populations of Medicaid beneficiaries, certain drug classes, or particular drugs to prevent fraud, abuse, overuse, and possible dangerous drug interactions. The Pharmaceutical and Therapeutics Committee shall make recommendations to the agency on drugs for which prior authorization is required. The agency shall inform the Pharmaceutical and Therapeutics Committee of its decisions regarding drugs subject to prior authorization. The agency is authorized to limit the entities it contracts with or enrolls as Medicaid providers by developing a provider network through provider credentialing. The agency may competitively bid single-source-provider contracts if procurement of goods or services results in demonstrated cost savings to the state without limiting access to care. The agency may limit its network based on the assessment of beneficiary access to care, provider availability, provider quality standards, time and distance standards for access to care, the cultural competence of the provider network, demographic characteristics of Medicaid beneficiaries, practice and provider-to-beneficiary standards, appointment wait times, beneficiary use of services, provider turnover, provider profiling, provider licensure history, previous program integrity investigations and findings, peer review, provider Medicaid policy and billing compliance records, clinical and medical record audits, and other factors. Providers shall not be entitled to enrollment in the Medicaid provider network. The agency shall determine instances in which allowing Medicaid beneficiaries to purchase durable medical equipment and other goods is less expensive to the Medicaid program than long-term rental of the equipment or goods. The agency may establish rules to facilitate purchases in lieu of long-term rentals in order to protect against fraud and abuse in the Medicaid program as defined in s. 409.913. The agency may seek federal waivers necessary to administer these policies.

(4) The agency may contract with:

(b) An entity that is providing comprehensive behavioral health care services to certain Medicaid recipients through a capitated, prepaid arrangement pursuant to the federal waiver provided for by s. 409.905(5). Such entity must be licensed under chapter 624, chapter 636, or chapter 641, or authorized under paragraph (c), and must possess the clinical systems and operational competence to manage risk and provide comprehensive behavioral health care to Medicaid recipients. As used in this paragraph, the term "comprehensive behavioral health care services" means covered mental health and substance abuse treatment services that are available to Medicaid recipients. The secretary of the Department of Children and Family Services shall approve provisions of procurements related to children in the department's care or custody before enrolling such children in a prepaid behavioral health plan. Any contract awarded under this paragraph must be competitively procured. In developing the behavioral health care prepaid plan procurement document, the agency shall ensure that the procurement document requires the contractor to develop and implement a plan to ensure compliance with s. 394.4574 related to services provided to residents of licensed assisted living facilities that hold a limited mental health license. Except as provided in subparagraph 8., and except in counties where the Medicaid managed care pilot program is authorized pursuant to s. 409.91211, the agency shall seek federal approval to contract with a single entity meeting these requirements to provide comprehensive behavioral health care services to all Medicaid recipients not enrolled in a Medicaid managed care plan authorized under s. 409.91211, a Medicaid provider service network authorized under paragraph (d), or a Medicaid health maintenance organization in an AHCA area. In an AHCA area where the Medicaid managed care pilot program is authorized pursuant to s. 409.91211 in one or more counties, the agency may procure a contract with a single entity to serve the remaining counties as an AHCA area or the remaining counties may be

included with an adjacent AHCA area and are subject to this paragraph. Each entity must offer a sufficient choice of providers in its network to ensure recipient access to care and the opportunity to select a provider with whom they are satisfied. The network shall include all public mental health hospitals. To ensure unimpaired access to behavioral health care services by Medicaid recipients, all contracts issued pursuant to this paragraph must require 80 percent of the capitation paid to the managed care plan, including health maintenance organizations or provider service networks, to be expended for the provision of behavioral health care services. If the managed care plan expends less than 80 percent of the capitation paid for the provision of behavioral health care services, the difference shall be returned to the agency. The agency shall provide the plan with a certification letter indicating the amount of capitation paid during each calendar year for behavioral health care services pursuant to this section. The agency may reimburse for substance abuse treatment services on a fee-for-service basis until the agency finds that adequate funds are available for capitated, prepaid arrangements.

1. By January 1, 2001, the agency shall modify the contracts with the entities providing comprehensive inpatient and outpatient mental health care services to Medicaid recipients in Hillsborough, Highlands, Hardee, Manatee, and Polk Counties, to include substance abuse treatment services.

2. By July 1, 2003, the agency and the Department of Children and Family Services shall execute a written agreement that requires collaboration and joint development of all policy, budgets, procurement documents, contracts, and monitoring plans that have an impact on the state and Medicaid community mental health and targeted case management programs.

3. Except as provided in subparagraph 8., by July 1, 2006, the agency and the Department of Children and Family Services shall contract with managed care entities in each AHCA area except area 6 or arrange to provide comprehensive inpatient and outpatient mental health and substance abuse services through capitated prepaid arrangements to all Medicaid recipients who are eligible to participate in such plans under federal law and regulation. In AHCA areas where eligible individuals number less than 150,000, the agency shall contract with a single managed care plan to provide comprehensive behavioral health services to all recipients who are not enrolled in a Medicaid health maintenance organization or a Medicaid capitated managed care plan authorized under s. 409.91211. The agency may contract with more than one comprehensive behavioral health provider to provide care to recipients who are not enrolled in a Medicaid capitated managed care plan authorized under s. 409.91211 or a Medicaid health maintenance organization in AHCA areas where the eligible population exceeds 150,000. In an AHCA area where the Medicaid managed care pilot program is authorized pursuant to s. 409.91211 in one or more counties, the agency may procure a contract with a single entity to serve the remaining counties as an AHCA area or the remaining counties may be included with an adjacent AHCA area and shall be subject to this paragraph. Contracts for comprehensive behavioral health providers awarded pursuant to this section shall be competitively procured. Both for-profit and not-for-profit corporations are eligible to compete. Managed care plans contracting with the agency under subsection (3) shall provide and receive payment for the same comprehensive behavioral health benefits as provided in AHCA rules, including handbooks incorporated by reference. In AHCA area 11, the agency shall contract with at least two comprehensive behavioral health care providers to provide behavioral health care to recipients in that area who are enrolled in, or assigned to, the MediPass program. One of the behavioral health care contracts must be with the existing provider service network pilot project, as described in paragraph (d), for the purpose of demonstrating the cost-effectiveness of the provision of quality mental health services through a public hospital-operated managed care model. Payment shall be at an agreed-upon capitated rate to ensure cost savings. Of the recipients in area 11 who are assigned to MediPass under s. 409.9122(2)(k), a minimum of 50,000 of those MediPass-enrolled recipients shall be assigned to the existing provider service network in area 11 for their behavioral care.

4. By October 1, 2003, the agency and the department shall submit a plan to the Governor, the President of the Senate, and the Speaker of the House of Representatives which provides for the full implementation of capitated prepaid behavioral health care in all areas of the state.

a. Implementation shall begin in 2003 in those AHCA areas of the state where the agency is able to establish sufficient capitation rates.

b. If the agency determines that the proposed capitation rate in any area is insufficient to provide appropriate services, the agency may adjust the capitation rate to ensure that care will be available. The agency and the department may use existing general revenue to address any additional required match but may not over-obligate existing funds on an annualized basis.

c. Subject to any limitations provided in the General Appropriations Act, the agency, in compliance with appropriate federal authorization, shall develop policies and procedures that allow for certification of local and state funds.

5. Children residing in a statewide inpatient psychiatric program, or in a Department of Juvenile Justice or a Department of Children and Family Services residential program approved as a Medicaid behavioral health overlay services provider may not be included in a behavioral health care prepaid health plan or any other Medicaid managed care plan pursuant to this paragraph.

6. In converting to a prepaid system of delivery, the agency shall in its procurement document require an entity providing only comprehensive behavioral health care services to prevent the displacement of indigent care patients by enrollees in the Medicaid prepaid health plan providing behavioral health care services from facilities receiving state funding to provide indigent behavioral health care, to facilities licensed under chapter 395 which do not receive state funding for indigent behavioral health care, or reimburse the unsubsidized facility for the cost of behavioral health care provided to the displaced indigent care patient.

7. Traditional community mental health providers under contract with the Department of Children and Family Services pursuant to part IV of chapter 394, child welfare providers under contract with the Department of Children and Family Services in areas 1 and 6, and inpatient mental health providers licensed pursuant to chapter 395 must be offered an opportunity to accept or decline a contract to participate in any provider network for prepaid behavioral health services.

8. All Medicaid-eligible children, except children in area 1 and children in Highlands County, Hardee County, Polk County, or Manatee County of area 6, that are open for child welfare services in the HomeSafeNet system, shall receive their behavioral health care services through a specialty prepaid plan operated by community-based lead agencies through a single agency or formal agreements among several agencies. The specialty prepaid plan must result in savings to the state comparable to savings achieved in other Medicaid managed care and prepaid programs. Such plan must provide mechanisms to maximize state and local revenues. The specialty prepaid plan shall be developed by the agency and the Department of Children and Family Services. The agency may seek federal waivers to implement this initiative. Medicaid-eligible children whose cases are open for child welfare services in the HomeSafeNet system and who reside in AHCA area 10 are exempt from the specialty prepaid plan upon the development of a service delivery mechanism for children who reside in area 10 as specified in s. 409.91211(3)(dd).

(d) A provider service network may be reimbursed on a fee-for-service or prepaid basis. A provider service network that ~~which~~ is reimbursed by the agency on a prepaid basis shall be exempt from parts I and III of chapter 641~~,~~ but must comply with the solvency requirements in s. 641.2261(2) and meet appropriate financial reserve, quality assurance, and patient rights requirements as established by the agency. Medicaid recipients assigned to a provider service network shall be chosen equally from those who would otherwise have been assigned to prepaid plans and MediPass. The agency may ~~is authorized to~~ seek federal Medicaid waivers as necessary to implement the provisions of this section. Any contract previously awarded to a provider service network operated by a hospital pursuant to this subsection shall remain in effect through June 30, 2015 ~~for a period of 3 years following the current contract expiration date~~, regardless of any contractual provisions to the contrary. A contract awarded or renewed on or after July 1, 2010, to a provider service network shall prohibit the cancellation of the contract unless the network provides the agency with at least 90 days' notice. All members of the network must continue to provide services to Medicaid recipients assigned to that network during that 90-day period. A provider service network is a

network established or organized and operated by a health care provider, or group of affiliated health care providers, including minority physician networks and emergency room diversion programs that meet the requirements of s. 409.91211, which provides a substantial proportion of the health care items and services under a contract directly through the provider or affiliated group of providers and may make arrangements with physicians or other health care professionals, health care institutions, or any combination of such individuals or institutions to assume all or part of the financial risk on a prospective basis for the provision of basic health services by the physicians, by other health professionals, or through the institutions. The health care providers must have a controlling interest in the governing body of the provider service network organization.

(54) An entity that contracts with the agency on a prepaid or fixed-sum basis for the provision of Medicaid services shall spend 85 percent of the Medicaid capitation revenue for health services to enrollees. The agency shall monitor medical loss ratios for all prepaid plans on a county-by-county basis. When a plan's 3-year average medical loss ratio in a county is less than 85 percent, the agency may recoup an amount equivalent to the difference between 85 percent of the capitation paid to the plan and the amount the plan paid for provision of services over the 3-year period. These recouped funds shall be dispersed in proportionate amounts to plans that have spent in excess of 85 percent of their capitation on the provision of medical services.

Section 4. Section 409.91207, Florida Statutes, is amended to read:

(Substantial rewording of section. See s. 409.91207, F.S., for present text.)

409.91207 Medical homes.—

(1) PURPOSE AND PRINCIPLES.—The agency shall develop a method for recognizing the certification of a primary care provider or a provider service network as a medical home. The purpose of this certification is to foster and support improved care management through enhanced primary care case management and dissemination of best practices for coordinated and cost-effective care. The medical home modifies the processes and patterns of health care service delivery by applying the following principles:

(a) A personal medical provider leads an interdisciplinary team of professionals who share the responsibility of providing ongoing care to a specific panel of patients.

(b) The personal medical provider identifies a patient's health care needs and responds to those needs through direct care or arrangements with other qualified providers.

(c) Care is coordinated or integrated across all areas of health service delivery.

(d) Information technology is integrated into delivery systems to enhance clinical performance and monitor patient outcomes.

(2) DEFINITIONS.—As used in this section, the term:

(a) "Case manager" means a person or persons employed by a medical home network or provider service network, or a member of such network, to work with primary care providers in the delivery of outreach, support services, and care coordination for medical home patients.

(b) "Medical home network" means a group of primary care providers and other health professionals and facilities who agree to cooperate with one another in order to coordinate care for Medicaid beneficiaries assigned to primary care providers in the network.

(c) "Primary care provider" means a health professional practicing in the field of family medicine, general internal medicine, geriatric medicine, or pediatric medicine who is licensed as a physician under chapter 458 or chapter 459, a physician's assistant performing services delegated by a supervising physician pursuant to s. 458.347 or s. 459.022, or a registered nurse certified as an advanced registered nurse practitioner performing services pursuant to a protocol established with a supervising physician in accordance with s. 464.012. The term "primary care provider" also means a federally qualified health center.

(d) "Principal network provider" means a member of a medical home network or a provider service network who serves as the principal liaison between the agency and that network and who accepts responsibility for communicating the agency's directives concerning the project to all other network members.

(e) "Provider service network" has the same meaning as provided in s. 409.912(4)(d).

(f) "Tier One medical home" means:

1. A primary care provider that certifies to the agency that the provider meets the service capabilities established in paragraph (4)(a); or

2. A provider service network that certifies to the agency that all of its members who are primary care providers meet the service capabilities established in paragraph (4)(a).

(g) "Tier Two medical home" means:

1. A primary care provider that certifies to the agency that the provider meets the service capabilities established in paragraph (4)(b); or

2. A provider service network that certifies to the agency that at least 85 percent of its members who are primary care providers meet the service capabilities established in paragraph (4)(b) and the remainder of the primary care providers meet the service capabilities established in paragraph (4)(a).

(h) "Tier Three medical home" means:

1. A primary care provider that certifies to the agency that the provider meets the service capabilities established in paragraph (4)(c); or

2. A provider service network that certifies to the agency that at least 85 percent of its members who are primary care providers meet the service capabilities established in paragraph (4)(c) and the remainder of the primary care providers meet the service capabilities established in paragraph (4)(b).

(3) ORGANIZATION.—

(a) Each participating primary care provider shall be a member of a medical home network or a provider service network and shall be classified by the agency as a Tier One, Tier Two, or Tier Three medical home upon certification by the provider of compliance with the service capabilities for that tier. A primary care provider or a provider service network may change classification by certifying service capabilities consistent with the standards for another tier. Certifications shall be made annually.

(b) Each participating provider service network shall be classified by the agency as a Tier One, Tier Two, or Tier Three medical home upon certification by the network that the network's primary care providers meet the service capabilities for that tier. The provider service network may also certify to the agency that it intends to serve a specific target population based on disease, condition, or age.

(c) The members of each medical home network or provider service network shall designate a principal network provider who shall be responsible for maintaining an accurate list of participating providers, forwarding this list to the agency, updating the list as requested by the agency, and facilitating communication between the agency and the participating providers.

(d) A provider service network may only cease participation as a medical home after providing at least 90 days' notice to the agency. All members of the provider service network must continue to serve the enrollees during this 90-day period. A provider service network that is reimbursed by the agency on a prepaid basis may not receive any additional reimbursements for this 90-day period.

(4) SERVICE CAPABILITIES.—A medical home network or a provider service network certified as a medical home shall provide primary care; coordinate services to control chronic illnesses; provide disease management and patient education; provide or arrange for pharmacy, outpatient diagnostic, and specialty physician services; and provide for or coordinate with inpatient facilities and behavioral health, mental health, and rehabilitative service providers. The network shall place a priority on methods to manage pharmacy and behavioral health services.

(a) Tier One medical homes shall have the capability to:

1. Maintain a written copy of the mutual agreement between the medical home and the patient in the patient's medical record.

2. Supply all medically necessary primary and preventive services and provide all scheduled immunizations.

3. Organize clinical data in paper or electronic form using a patient-centered charting system.

4. Maintain and update patients' medication lists and review all medications during each office visit.

5. Maintain a system to track diagnostic tests and provide followup services regarding test results.

6. Maintain a system to track referrals, including self-referrals by members.

7. Supply care coordination and continuity of care through proactive contact with members and encourage family participation in care.

8. Supply education and support using various materials and processes appropriate for individual patient needs.

(b) Tier Two medical homes shall have all of the capabilities of a Tier One medical home and shall have the additional capability to:

1. Communicate electronically.

2. Supply voice-to-voice telephone coverage to panel members 24 hours per day, 7 days per week, to enable patients to speak to a licensed health care professional who triages and forwards calls, as appropriate.

3. Maintain an office schedule of at least 30 scheduled hours per week.

4. Use scheduling processes to promote continuity with clinicians, including providing care for walk-in, routine, and urgent care visits.

5. Implement and document behavioral health and substance abuse screening procedures and make referrals as needed.

6. Use data to identify and track patients' health and service use patterns.

7. Coordinate care and followup for patients receiving services in inpatient and outpatient facilities.

8. Implement processes to promote access to care and member communication.

(c) Tier Three medical homes shall have all of the capabilities of Tier One and Tier Two medical homes and shall have the additional capability to:

1. Maintain electronic medical records.

2. Develop a health care team that provides ongoing support, oversight, and guidance for all medical care received by the patient and documents contact with specialists and other health care providers caring for the patient.

3. Supply postvisit followup care for patients.

4. Implement specific evidence-based clinical practice guidelines for preventive and chronic care.

5. Implement a medication reconciliation procedure to avoid interactions or duplications.

6. Use personalized screening, brief intervention, and referral to treatment procedures for appropriate patients requiring specialty treatment.

7. Offer at least 4 hours per week of after-hours care to patients.

8. Use health assessment tools to identify patient needs and risks.

(5) TASK FORCE; ADVISORY PANEL.—

(a) The Secretary of Health Care Administration shall appoint a task force by August 1, 2009, to assist the agency in the development and implementation of the medical home pilot project. The task force must include, but is not limited to, representatives of providers who could potentially participate in a medical home network, Medicaid recipients, and existing MediPass and managed care providers. Members of the task force shall serve without compensation but are may be reimbursed for per diem and travel expenses as provided in s. 112.061. When the statewide advisory panel created pursuant to paragraph (b) has been appointed, the task force shall dissolve.

(b) A statewide advisory panel shall be established to advise and assist the agency in developing a methodology for an annual evaluation of each medical home network and provider service network certified as a medical home. The panel shall promote communication among medical home networks and provider service networks certified as medical homes. The panel shall consist of seven members, as follows:

1. Two members appointed by the Speaker of the House of Representatives, one of whom shall be a primary care physician licensed under chapter 458 or chapter 459 and one of whom shall be a representative of a hospital licensed under chapter 395.

2. Two members appointed by the President of the Senate, one of whom shall be a physician licensed under chapter 458 or chapter 459 who is a board-certified specialist and one of whom shall be a representative of a Florida medical school.

3. Two members appointed by the Governor, one of whom shall be a representative of an insurer licensed to do business in this state or a health maintenance organization licensed under part I of chapter 641 and one of whom shall be a representative of Medicaid consumers.

4. The Secretary of Health Care Administration or his or her designee.

(c) Appointed members of the panel shall serve 4-year terms, except that the initial terms shall be staggered as follows:

1. The Governor shall appoint one member for a term of 2 years and one member for a term of 4 years.

2. The President of the Senate shall appoint one member for a term of 2 years and one member for a term of 4 years.

3. The Speaker of the House of Representatives shall appoint one member for a term of 2 years and one member for a term of 4 years.

(d) A vacancy in an appointed member's position shall be filled by appointment by the original appointing authority for the unexpired portion of the term.

(e) Members of the statewide advisory panel shall serve without compensation but may be reimbursed for per diem and travel expenses as provided in s. 112.061.

(f) The agency shall provide staff support to assist the panel in the performance of its duties.

(g) The statewide advisory panel shall establish a medical advisory group consisting of physicians licensed under chapter 458 or chapter 459 who shall act as ambassadors to their communities for the promotion of and assistance in the establishment of medical home networks and provider service networks certified as medical homes. Members of the medical advisory group shall serve without compensation but may be reimbursed for per diem and travel expenses as provided in s. 112.061.

(6) ENROLLMENT.—Each MediPass beneficiary served by a certified Tier One, Tier Two, or Tier Three medical home shall be given a choice to enroll in a medical home network or provider service network certified as a medical home. Enrollment shall be effective upon the agency's receipt of a participation agreement signed by the beneficiary.

(7) FINANCING.—

(a) Subject to a specific appropriation provided for in the General Appropriations Act, medical home network members shall be eligible to receive a monthly enhanced case management fee, as follows:

1. Tier One medical homes shall receive $3.58 per child in a panel of enrollees and $5.02 per adult in a panel of enrollees.

2. Tier Two medical homes shall receive $4.65 per child in a panel of enrollees and $6.52 per adult in a panel of enrollees.

3. Tier Three medical homes shall receive $6.12 per child in a panel of enrollees and $8.69 per adult in a panel of enrollees.

(b) Services provided by a medical home network or a provider service network with a fee-for-service contract with the agency shall be reimbursed based on claims filed for Medicaid fee-for-service payments. Services by a provider service network with a contract with the agency for prepaid services shall be paid pursuant to the contract and shall be eligible to receive the credit provided in this subsection.

(c) Any hospital, as defined in s. 395.002(12), participating in a medical home network or service provider network certified as a medical home that employs case managers for the network shall be eligible to receive a credit against the assessment imposed under s. 395.701. The credit is compensation for participating in the network by providing case management and other network services.

1. The credit shall be prorated based on the number of full-time equivalent case managers hired but shall not be more than $75,000 for each full-time equivalent case manager. The total credit may not exceed $450,000 for any hospital for any state fiscal year.

2. To qualify for the credit, the hospital must employ each full-time equivalent case manager for the entire hospital fiscal year for which the credit is claimed.

3. The hospital must certify the number of full-time equivalent case managers for whom it is entitled to a credit using the certification process required under s. 395.701(2)(a).

4. The agency shall calculate the amount of the credit and reduce the certified assessment for the hospital by the amount of the credit.

(d) The enhanced payments to primary care providers shall not affect the calculation of capitated rates under this chapter.

(8) AGENCY DUTIES.—The agency shall:

(a) Maintain a record of certified primary care providers and provider service networks by classification as Tier One, Tier Two, or Tier Three medical homes.

(b) Develop a standard form to be used by primary care providers and provider service networks to certify to the agency that they meet the necessary principles and service capabilities for the tier in which they seek to be classified. The form shall have a check box for each of the three tiers, a line to indicate whether a primary care network intends to specialize in a target population, a line to specify the target population, if any, and a line for the signature of the provider or principal of an entity. Checking the appropriate tier box and signing the form shall be deemed certification for the purposes of this section.

(c) Develop a process for managed care organizations to certify themselves as Tier One, Tier Two, or Tier Three medical homes based on established policies and procedures consistent with the principles and corresponding service capabilities provided under subsections (1) and (4).

(d) Establish a participation agreement to be executed by Medipass recipients who choose to participate in the medical home pilot project.

(e) Track the spending for and utilization of services by all enrolled medical home network patients.

(f) Evaluate each provider service network at least annually to ensure that the network is cost-effective as defined in s. 409.912(44).

(9) ACHIEVED SAVINGS.—Each medical home network or provider service network certified as a medical home that participates on a fee-for-service basis and achieves savings equal to or greater than the spending that would have occurred if its enrollees participated in prepaid health plans is eligible to receive funding based on the identified savings pursuant to a specific appropriation provided for in the General Appropriations Act. The funds must be distributed on a pro rata basis to the physicians who are members of the medical home network so that the compensation for their services is as close as possible to 100 percent of Medicare rates. Subject to a specific appropriation, it is the intent of the Legislature that the savings that result from the implementation of the medical home network model be used to enable Medicaid fees to physicians participating in medical home networks to be equivalent to 100 percent of Medicare rates as soon as possible.

(10) COLLABORATION WITH PRIVATE INSURERS.—To enable the state to participate in federal gainsharing initiatives, the agency shall collaborate with the Office of Insurance Regulation to encourage insurers licensed in this state to incorporate medical home network principles into the design of their individual and employment-based plans. The Department of Management Services is directed to develop a medical home option in the state group insurance program.

(11) QUALITY ASSURANCE AND ACCOUNTABILITY.—Each primary care and principal network provider participating in a medical home network or provider service network certified as a medical home shall maintain medical records and clinical data necessary for the network to assess the use, cost, and outcome of services provided to enrollees.

Section 5. Paragraph (b) of subsection (1) and paragraph (e) of subsection (3) of section 409.91211, Florida Statutes, are amended to read:

409.91211 Medicaid managed care pilot program.—

(1)

(b) This waiver authority is contingent upon federal approval to preserve the upper-payment-limit funding mechanism for hospitals, including a guarantee of a reasonable growth factor, a methodology to allow the use of a portion of these funds to serve as a risk pool for demonstration sites, provisions to preserve the state's ability to use intergovernmental transfers, and provisions to protect the disproportionate share program authorized pursuant to this chapter. Upon completion of the evaluation conducted under s. 3, ch. 2005-133, Laws of Florida, the agency may request statewide expansion of the demonstration projects. Statewide phase-in to additional counties shall be contingent upon review and approval by the Legislature. Under the upper-payment-limit program, or the low-income pool as implemented by the Agency for Health Care Administration pursuant to federal waiver, the state matching funds required for the program shall be provided by local governmental entities through intergovernmental transfers in accordance with published federal statutes and regulations. The Agency for Health Care Administration shall distribute upper-payment-limit, disproportionate share hospital, and low-income pool funds according to published federal statutes, regulations, and waivers and the low-income pool methodology approved by the federal Centers for Medicare and Medicaid Services. A provider who receives low-income pool funds shall serve Medicaid recipients regardless of the recipient's county of residence in the state and may not restrict access to care based on residency in a county in the state other than the one in which the provider is located.

(3) The agency shall have the following powers, duties, and responsibilities with respect to the pilot program:

(e) To implement policies and guidelines for phasing in financial risk for approved provider service networks that, for purposes of this paragraph, include the Children's Medical Services Network, over the longer of a 5-year period or through October 1, 2015. These policies and guidelines must include an option for a provider service network to be paid fee-for-service rates. For any provider service network established in a managed care pilot area, the option to be paid fee-for-service rates must include a savings-settlement mechanism that is consistent with s. 409.912(44). As of October 1, 2015, or after 5 years of operation, whichever is the longer period, this model must be converted to a risk-adjusted capitated rate ~~by the beginning of the sixth year of operation,~~ and may be converted earlier at the option of the provider service network. Federally qualified health centers may be offered an opportunity to accept or decline a contract to participate in any provider network for prepaid primary care services.

Section 6. Paragraph (f) of subsection (2) of section 409.9122, Florida Statutes, is amended, and subsections (15) through (18) are added to that section, to read:

409.9122 Mandatory Medicaid managed care enrollment; programs and procedures.—

(2)

(f) If a Medicaid recipient does not choose a managed care plan or MediPass provider, the agency shall assign the Medicaid recipient to a managed care plan or MediPass provider. Medicaid recipients eligible for managed care plan enrollment who are subject to mandatory assignment but who fail to make a choice shall be assigned to managed care plans until an enrollment of ~~,~~ 65 percent in provider service networks certified as medical homes under s. 409.91207 and 35 percent in other managed care plans ~~35 percent in MediPass and 65 percent in managed care plans, of all those eligible to choose managed care,~~ is achieved. Once this enrollment is achieved, the assignments shall be divided in the same manner ~~order~~ to maintain the same ~~an~~ enrollment ratio ~~in MediPass and managed care plans which is in a 35 percent and 65 percent proportion, respectively~~. Thereafter, assignment of Medicaid recipients who fail to make a choice shall be based proportionally on the preferences of recipients who have made a choice in the previous period. Such proportions shall be revised at least quarterly to reflect an update of the preferences of Medicaid recipients. The agency shall disproportionately assign Medicaid-eligible recipients who are required to but have failed to make a choice of managed care plan or MediPass, including children, and who would be assigned to the MediPass program to children's networks as described in s. 409.912(4)(g), Children's Medical Services Network as defined in s. 391.021, exclusive provider organizations, provider service networks, minority physician networks, and pediatric emergency department diversion programs authorized by this chapter or the General Appropriations Act, in such manner as the agency deems appropriate, until the agency has determined that the networks and programs have sufficient numbers to be operated economically. For purposes of this paragraph, when referring to assignment, the term "managed care plans" includes health maintenance organizations, exclusive provider organizations, provider service networks, minority physician networks, Children's Medical Services Network, and pediatric emergency department diversion programs authorized by this chapter or the General Appropriations Act. When making assignments, the agency shall take into account the following criteria:

1. A managed care plan has sufficient network capacity to meet the need of members.

2. The managed care plan or MediPass has previously enrolled the recipient as a member, or one of the managed care plan's primary care providers or MediPass providers has previously provided health care to the recipient.

3. The agency has knowledge that the member has previously expressed a preference for a particular managed care plan or MediPass provider as indicated by Medicaid fee-for-service claims data, but has failed to make a choice.

4. The managed care plan's or MediPass primary care providers are geographically accessible to the recipient's residence.

(15)(a) Beginning September 1, 2010, the agency shall begin a budget-neutral adjustment of capitation rates for all Medicaid prepaid plans in the state. The adjustment to capitation rates shall be based on aggregate risk scores for each prepaid plan's enrollees. During the first 2 years of the adjustment, the agency shall ensure that no plan has an aggregate risk score that varies more than 10 percent from the aggregate weighted average for all plans. The risk adjusted capitation rates shall be phased in as follows:

1. In the first fiscal year, 75 percent of the capitation rate shall be based on the current methodology and 25 percent shall be based on the risk-adjusted rate methodology.

2. In the second fiscal year, 50 percent of the capitation rate shall be based on the current methodology and 50 percent shall be based on the risk-adjusted methodology.

3. In the third fiscal year, the risk-adjusted capitation methodology shall be fully implemented.

(b) During this period, the agency shall establish a technical advisory panel to obtain input from the prepaid plans affected by the transition to risk adjusted rates.

(16) The agency shall maintain and operate the Medicaid Encounter Data System to collect, process, store, and report on covered services provided to all Florida Medicaid recipients enrolled in prepaid managed care plans. Prepaid managed care plans shall submit encounter data electronically in a format that complies with the Health Insurance Portability and Accountability Act provisions for electronic claims and in accordance with deadlines established by the agency. Prepaid managed care plans must certify that the data reported is accurate and complete. The agency is responsible for validating the data submitted by the plans.

(17) The agency shall establish, and managed care plans shall use, a uniform method of accounting for and reporting medical and nonmedical costs. The agency shall make such information available to the public.

(18) The agency may, on a case-by-case basis, exempt a recipient from mandatory enrollment in a managed care plan when the recipient has a unique, time-limited disease or condition-related circumstance and managed care enrollment will interfere with ongoing care because the recipient's provider does not participate in the managed care plans available in the recipient's area.

Section 7. Section 409.91225, Florida Statutes, is created to read:

409.91225 Managed care plan accountability.—The agency shall establish and implement managed care plans that shall use a uniform method of accounting for and reporting medical, direct care management, and nonmedical costs. The agency shall evaluate plan spending patterns beginning after the plan completes 2 full years of operation and at least annually thereafter. The agency shall implement the following thresholds and consequences of various spending patterns:

(1) Plans that spend less than 75 percent of Medicaid premium revenue on medical services and direct care management as determined by the agency shall be excluded from automatic enrollments and shall be required to pay back the amount between actual spending and 85 percent of the Medicaid premium revenue.

(2) Plans that spend less than 85 percent of Medicaid premium revenue on medical services and direct care management as determined by the agency shall be required to pay back the amount between actual spending and 85 percent of the Medicaid premium revenue.

(3) Plans that spend more than 95 percent of Medicaid premium revenue shall be evaluated by the agency to determine whether higher expenditures are the result of failures in care management. Such a determination may result in the plan being excluded from automatic enrollments.

Section 8. This act shall take effect July 1, 2010.

T I T L E A M E N D M E N T

Remove the entire title and insert:

A bill to be entitled

An act relating to Medicaid; amending s. 409.907, F.S.; revising the requirements of a Medicaid provider agreement to include compliance with the Medicaid Encounter Data System; requiring the Agency for Health Care Administration to submit an annual report on the system to the Governor and Legislature; amending s. 409.908, F.S.; requiring the agency to adjust capitation rates for certain Medicaid providers; providing criteria for the adjustments; providing a phase-in schedule; requiring the Secretary of Health Care Administration to establish a technical advisory panel to advise the agency in the area of risk-adjusted rate setting; providing membership and duties; amending s. 409.912, F.S.; providing instructions to the agency regarding seeking federal approval for certain contracts that provide behavioral health care services; providing for certain contracts to remain in effect until a specified date; prohibiting the cancellation of certain contracts with provider service networks without specified notice; providing additional terms for cancellation; requiring contracts for Medicaid services that are on a prepaid or fixed-sum basis to meet certain medical loss ratios; providing for the agency to recoup and redistribute payments under certain circumstances; amending s. 409.91207, F.S.; providing purposes and principles for creating medical homes; providing definitions; providing for the organization of medical home networks and provider service networks certified as medical homes; requiring a provider service network to provide certain notice to the agency prior to ceasing participation as a medical home; requiring each medical home to provide specified services; providing for abolishment of a task force upon the creation of a statewide advisory panel; providing for the establishment of the statewide advisory panel; providing membership, terms, and duties; directing the agency to provide staff support to the panel; directing the panel to establish a medical advisory group to assist in the establishment of medical home networks and provider service networks certified as medical homes; providing for travel expenses and per diem for members of the panel and the medical advisory group; providing for enrollment of MediPass beneficiaries in medical homes; providing for financing of medical home networks; providing duties of the agency; providing for distribution of savings achieved by network providers under certain circumstances; requiring the agency to collaborate with the Office of Insurance Regulation to encourage licensed insurers to incorporate the principles of the medical home network into insurance plans; requiring the Department of Management Services to develop a medical home option in the state group insurance program; requiring medical home network providers to maintain certain records and data; amending s. 409.91211, F.S.; requiring a provider that receives low-income pool funds to serve Medicaid recipients regardless of county of residence; revising the period for phasing in financial risk for certain provider service networks; amending s. 409.9122, F.S.; revising the assignment of Medicaid recipients eligible for managed care plan enrollment who are subject to mandatory assignment but who fail to make a choice; requiring the Agency for Health Care Administration to begin a budget-neutral adjustment of capitation rates for all Medicaid prepaid plans in the state on a specified date; providing the basis for the adjustment; providing a phased schedule for risk adjusted capitation rates; providing for the establishment of a technical advisory panel; requiring the agency to maintain and operate the Medicaid Encounter Data System; requiring the agency to establish, and managed care plans to use, a uniform method of accounting for and reporting of medical and nonmedical costs; authorizing the Agency for Health Care Administration to create exceptions to mandatory enrollment in managed care under specified circumstances; creating s. 409.91225, F.S.; establishing managed care plan accountability; creating a medical-loss ratio requirement; providing an effective date.

Rep. Pafford moved the adoption of the amendment. Subsequently, **Amendment 33** was withdrawn.

Under Rule 10.10(b), the bill was referred to the Engrossing Clerk.

Caribbean Day Celebration

The Speaker recognized Rep. Rogers to approach the well to celebrate Caribbean Heritage Day. She was joined by Reps. Bernard, Bullard, Carroll, Clarke-Reed, Y. Roberson, and Thurston.

Representative Clarke-Reed: Thank you, Mr. Speaker. Members, we are here today in celebration of the diverse culture of the Caribbean, the rebirth of Haiti, and to declare June 2010 as Caribbean American Heritage Month. Please enjoy this brief glimpse of the Caribbean countries which are represented by members in this Chamber.

Representative Rogers: Thank you, members. I join my colleagues in celebration today and read portions of the proclamation from our Governor.

Caribbean American Heritage Month

Whereas, during Caribbean American Heritage Month, we celebrate the great contributions of Caribbean Americans to the fabric of our nation; and

Whereas, for 2008-10, this body is represented by members from the islands of the Bahamas, Haiti, Jamaica, Trinidad and Tobago, and we are celebrating their culture in April in this Capitol;

Whereas, during the month of June, we honor the friendships between the United States and the Caribbean;

Now, therefore, Charlie Crist, Governor of the State of Florida, do hereby extend greetings and best wishes to all observing June 2010 as Caribbean American Heritage Month; and

Witness thereto, he has set his hands and calls the Great Seal of the State of Florida to be affixed to this, in Tallahassee, this Capitol, on 15th day of April, 2010. Thank you.

Representative Bernard: Members, with great regrets, Rep. Brisé was not able to be here today. But you get the consolation prize of me presenting the video that shares the heritage and culture of the members' island. Thank you.

[A video presentation was shown.]

Representative Y. Roberson: On behalf of the Caribbean Caucus, I'd like to take this opportunity to thank all of you for sharing with us, for enjoying a little bit of our culture. As you can see, we are all better for it. When we get together, when we learn from each other, we can do so much better. Thank you very much.

Representative Thurston: Members, I want to take this opportunity to thank you, and to thank the students from FAMU who helped with overseeing the artifacts in the courtyard earlier this afternoon, and hopefully, you all got to see them, as well. But I also want to tell you that I hope you enjoyed the Caribbean food that was in the lunchroom. I heard from Representative Culp and Representative Bogdanoff that it was a little bit spicy for their taste, and we'll take that into consideration the next time—but hopefully, you enjoyed it, members. Thank you.

Representative Bullard: Thank you, members. I would also like to recognize and thank our minister for today, Pastor Paulicin, as well as the dignitaries that were in the galleries earlier today. But I'd also like to acknowledge the following folks: I want to thank Lawrence Gonzalez, the fine folks at FAVACA, Michelle Fowler, Patricia Amiel-Young, and Pamela Paultre for organizing it, and helping to organize today's events. For those who didn't get a chance to participate in the courtyard, it was phenomenal—performances and a definite show of artifacts. So, we do hope that as we continue the celebration of Caribbean Heritage, here in the Florida Capitol, that we take full advantage of the width and breadth of the Caribbean influence in Florida. Thank you.

Representative Carroll: Mr. Speaker, members, thank you very much for indulging us today to share in the celebration of Caribbean Heritage Day. From the Bahamas, we have Oscar Braynon, Dwight Bullard, Gwyn Clarke-Reed, and Perry Thurston; from Haiti, we have Mack Bernard, Ron Brisé, Yolly Roberson; from Jamaica, Hazelle Rogers; and Trinidad and Tobago, Jennifer Carroll. Thank you very much.

THE SPEAKER PRO TEMPORE IN THE CHAIR

Motion

Rep. Carroll moved that the events held on April 15 during the Caribbean Day Celebration be spread upon the *Journal*. Under Rule 8.2(b), the Chair [Speaker pro tempore Reagan] referred the motion to Rep. Galvano, Chair of the Rules & Calendar Council, for a recommendation.

Rep. Galvano recommended that the motion be given to the vote of the Chamber. The Chair [Speaker pro tempore Reagan] agreed with the recommendation, and the motion was agreed to.

HB 7225—A bill to be entitled An act relating to Medicaid; amending s. 393.0661, F.S., relating to the home and community-based services delivery system for persons with developmental disabilities; requiring the Agency for Persons with Disabilities to establish a transition plan for current Medicaid recipients under certain circumstances; providing for expiration of the section on a specified date; creating s. 400.0713, F.S.; requiring the Agency for Health Care Administration to establish a nursing home licensure workgroup; amending s. 408.040, F.S.; providing for suspension of conditions precedent to the issuance of a certificate of need for a nursing home, effective on a specified date; amending s. 408.0435, F.S.; extending the certificate-of-need moratorium for additional community nursing home beds; designating ss. 409.016-409.803, F.S., as pt. I of ch. 409, F.S., and entitling the part "Social and Economic Assistance"; designating ss. 409.810-409.821, F.S., as pt. II of ch. 409, F.S., and entitling the part "Kidcare"; designating ss. 409.901-409.9205, F.S., as part III of ch. 409, F.S., and entitling the part "Medicaid"; amending s. 409.907, F.S.; authorizing the Agency for Health Care Administration to enroll entities as Medicare crossover-only providers for payment purposes only; specifying requirements for Medicare crossover-only agreements; amending s. 409.908, F.S.; providing penalties for providers that fail to report suspension or disenrollment from Medicare within a specified time; amending s. 409.912, F.S.; authorizing provider service networks to provide comprehensive behavioral health care services to certain Medicaid recipients; providing payment requirements for provider service networks; providing for the expiration of various provisions of the section on specified dates to conform to the reorganization of Medicaid managed care; eliminating obsolete provisions and updating provisions within the section; amending ss. 409.91195 and 409.91196, F.S.; conforming cross-references; amending s. 409.91207, F.S.; providing authority of the Agency for Health Care Administration with respect to the development of a method for designating qualified plans as a medical home network; providing purposes and principles for creating medical home networks; providing criteria for designation of a qualified plan as a medical home network; providing agency duties with respect thereto; amending s. 409.91211, F.S.; providing authority of the Agency for Health Care Administration to implement a managed care pilot program based on specified waiver authority with respect to the Medicaid reform program; continuing the existing pilot program in specified counties; requiring the agency to seek an extension of the waiver; providing for monthly reports; requiring approval of the Legislative Budget Commission for changes to specified terms and conditions ; providing for expansion of the managed care pilot program to Miami-Dade County; specifying managed care plans that are qualified to participate in the Medicaid managed care pilot program; providing requirements for qualified managed care plans; requiring the agency to develop and seek federal approval to implement methodologies to preserve intergovernmental transfers of funds and certified public expenditures from

Miami-Dade County; requiring the agency to submit a plan and specified amendment to the Legislative Budget Commission; providing for a report; requiring Medicaid recipients in counties in which the managed care pilot program has been implemented to be enrolled in a qualified plan; providing a time limit for enrollment; requiring the agency to provide choice counseling; providing requirements with respect to choice counseling information provided to Medicaid recipients; providing for automatic enrollment of certain Medicaid recipients; establishing criteria for automatic enrollment; providing procedures and requirements with respect to voluntary disenrollment of a recipient in a qualified plan; providing for an enrollment period; requiring qualified plans to establish a process for review of and response to grievances of enrollees; requiring qualified plans to submit quarterly reports; specifying services to be covered by qualified plans; authorizing qualified plans to offer specified customizations, variances, and coverage for additional services; requiring agency evaluation of proposed benefit packages; requiring qualified plans to reimburse the agency for the cost of specified enrollment changes; providing for access to encounter data; requiring participating plans to establish an incentive program to reward healthy behaviors; requiring the agency to continue budget-neutral adjustment of capitation rates for all prepaid plans in existing managed care pilot program counties; providing for transition to payment methodologies for Miami-Dade County plans; providing a phased schedule for risk-adjusted capitation rates; requiring the establishment of a technical advisory panel; providing for distribution of funds from a low-income pool; specifying purposes for such distribution; requiring the agency to maintain and operate the Medicaid Encounter Data System; requiring the agency to contract with the University of Florida for evaluation of the pilot program; amending s. 409.9122, F.S.; eliminating outdated provisions; providing for the expiration of various provisions of the section on specified dates to conform to the reorganization of Medicaid managed care; requiring the Agency for Health Care Administration to begin a budget-neutral adjustment of capitation rates for all Medicaid prepaid plans in the state on a specified date; providing the basis for the adjustment; providing a phased schedule for risk adjusted capitation rates; providing for the establishment of a technical advisory panel; requiring the agency to develop a process to enable any recipient with access to employer sponsored insurance to opt out of qualified plans in the Medicaid program; requiring the agency, contingent on federal approval, to enable recipients with access to other insurance or related products providing access to specified health care services to opt out of qualified plans in the Medicaid program; providing a limitation on the amount of financial assistance provided for each recipient; requiring each qualified plan to establish an incentive program that rewards specific healthy behaviors; requiring plans to maintain a specified reserve account; requiring the agency to maintain and operate the Medicaid Encounter Data System; requiring the agency to establish a designated payment for specified Medicare Advantage Special Needs members; authorizing the agency to develop a designated payment for Medicaid-only covered services for which the state is responsible; requiring the agency to establish, and managed care plans to use, a uniform method of accounting for and reporting of medical and nonmedical costs; requiring reimbursement by Medicaid of school districts participating in a certified school match program for a Medicaid-eligible child participating in the services, effective on a specified date; requiring the agency, the Department of Health, and the Department of Education to develop procedures for ensuring that a student's managed care plan receives information relating to services provided; authorizing the Agency for Health Care Administration to create exceptions to mandatory enrollment in managed care under specified circumstances; amending s. 430.04, F.S.; eliminating outdated provisions; requiring the Department of Elderly Affairs to develop a transition plan for specified elder and disabled adults receiving long-term care Medicaid services when qualified plans become available; providing for expiration thereof; amending s. 430.2053, F.S.; eliminating outdated provisions; providing additional duties of aging resource centers; providing an additional exception to direct services that may not be provided by an aging resource center; providing for the cessation of specified payments by the department as qualified plans become available; providing for a memorandum of understanding between the Agency for Health Care Administration and aging resource centers under certain circumstances; eliminating provisions requiring reports; amending s. 641.386, F.S.; conforming a cross-reference; repealing s. 430.701, F.S., relating to legislative findings and intent and approval for action relating to provider enrollment levels; repealing s. 430.702, F.S., relating to the Long-Term Care Community Diversion Pilot Project Act; repealing s. 430.703, F.S., relating to definitions; repealing s. 430.7031, F.S., relating to nursing home transition program; repealing s. 430.704, F.S., relating to evaluation of long-term care through the pilot projects; repealing s. 430.705, F.S., relating to implementation of long-term care community diversion pilot projects; repealing s. 430.706, F.S., relating to quality of care; repealing s. 430.707, F.S., relating to contracts; repealing s. 430.708, F.S., relating to certificate of need; repealing s. 430.709, F.S., relating to reports and evaluations; renumbering ss. 409.9301, 409.942, 409.944, 409.945, 409.946, 409.953, and 409.9531, F.S., as ss. 402.81, 402.82, 402.83, 402.84, 402.85, 402.86, and 402.87, F.S., respectively; amending s. 443.111, F.S.; conforming a cross-reference; providing contingent effective dates.

—was read the second time by title.

Representative Grimsley offered the following:

(Amendment Bar Code: 311719)

Amendment 1 (with title amendment)—Remove lines 379-384 and insert:

(9)(a) The agency, in consultation with the Agency for Health Care Administration, shall establish an individual budget, referred to as an iBudget, demonstration project for each individual served through the Medicaid waiver program in Escambia, Okaloosa, Santa Rosa, and Walton Counties, which comprise area one of the agency. For the purpose of this subsection, the Medicaid waiver program includes the four-tiered waiver system established in subsection (3) or the Consumer Directed Care Plus Medicaid waiver program. The funds appropriated to the agency and used for Medicaid waiver program services to individuals in the demonstration project area shall be allocated through the iBudget system to eligible, Medicaid-enrolled clients. The iBudget system shall be designed to provide for enhanced client choice within a specified service package, appropriate assessment strategies, an efficient consumer budgeting and billing process that includes reconciliation and monitoring components, a redefined role for support coordinators that avoids potential conflicts of interest, a flexible and streamlined service review process, and a methodology and process that ensure the equitable allocation of available funds to each client based on the client's level of need, as determined by the variables in the allocation algorithm.

1. In developing each client's iBudget, the agency shall use an allocation algorithm and methodology. The algorithm shall use variables that have been determined by the agency to have a statistically validated relationship to the client's level of need for services provided through the Medicaid waiver program. The algorithm and methodology may consider individual characteristics, including, but not limited to, a client's age and living situation, information from a formal assessment instrument that the agency determines is valid and reliable, and information from other assessment processes.

2. The allocation methodology shall provide the algorithm that determines the amount of funds allocated to a client's iBudget. The agency may approve an increase in the amount of funds allocated, as determined by the algorithm, based on the client's having one or more of the following needs that cannot be accommodated within the funding as determined by the algorithm and having no other resources, supports, or services available to meet those needs:

a. An extraordinary need that would place the health and safety of the client, the client's caregiver, or the public in immediate, serious jeopardy unless the increase is approved. An extraordinary need may include, but is not limited to:

(I) A documented history of significant, potentially life-threatening behaviors, such as recent attempts at suicide, arson, nonconsensual sexual behavior, or self-injurious behavior requiring medical attention;

(II) A complex medical condition that requires active intervention by a licensed nurse on an ongoing basis that cannot be taught or delegated to a nonlicensed person;

(III) A chronic co-morbid condition. As used in this sub-sub-subparagraph, the term "co-morbid condition" means a medical condition existing simultaneously with but independently of another medical condition in a patient; or

(IV) A need for total physical assistance with activities such as eating, bathing, toileting, grooming, and personal hygiene.

However, the presence of an extraordinary need alone does not warrant an increase in the amount of funds allocated to a client's iBudget as determined by the algorithm.

b. A significant need for one-time or temporary support or services that, if not provided, would place the health and safety of the client, the client's caregiver, or the public in serious jeopardy unless the increase is approved. A significant need may include, but is not limited to, the provision of environmental modifications, durable medical equipment, services to address the temporary loss of support from a caregiver, or special services or treatment for a serious temporary condition when the service or treatment is expected to ameliorate the underlying condition. As used in this sub-subparagraph, the term "temporary" means lasting for a period of less than 12 consecutive months. However, the presence of such significant need for one-time or temporary support or services alone does not warrant an increase in the amount of funds allocated to a client's iBudget as determined by the algorithm.

c. A significant increase in the need for services after the beginning of the service plan year that would place the health and safety of the client, the client's caregiver, or the public in serious jeopardy because of substantial changes in the client's circumstances, including, but not limited to, permanent or long-term loss or incapacity of a caregiver, loss of services authorized under the state Medicaid plan due to a change in age, or a significant change in medical or functional status that requires the provision of additional services on a permanent or long-term basis that cannot be accommodated within the client's current iBudget. As used in this sub-subparagraph, the term "long-term" means lasting for a period of more than 12 continuous months. However, such significant increase in need for services of a permanent or long-term nature alone does not warrant an increase in the amount of funds allocated to a client's iBudget as determined by the algorithm.

The agency shall reserve portions of the appropriation for the home and community-based services Medicaid waiver program for adjustments required pursuant to this subparagraph and may use the services of an independent actuary in determining the amount of the portions to be reserved.

3. A client's iBudget shall be the total of the amount determined by the algorithm and any additional funding provided under subparagraph 2. A client's annual expenditures for Medicaid waiver services may not exceed the limits of his or her iBudget.

(b) The Agency for Health Care Administration, in consultation with the agency, shall seek federal approval for the iBudget demonstration project and amend current waivers, request a new waiver if appropriate, and amend contracts as necessary to implement the iBudget system to serve eligible, enrolled clients in the demonstration project area through the Medicaid waiver program.

(c) The agency shall transition all eligible, enrolled clients in the demonstration project area to the iBudget system. The agency may gradually phase in the iBudget system with full implementation by January 1, 2013.

1. The agency shall design the phase-in process to ensure that a client does not experience more than one-half of any expected overall increase or decrease to his or her existing annualized cost plan during the first year that the client is provided an iBudget due solely to the transition to the iBudget system. However, all iBudgets in the demonstration project area must be fully phased in by January 1, 2013.

(d) A client must use all available services authorized under the state Medicaid plan, school-based services, private insurance and other benefits, and any other resources that may be available to the client before using funds from his or her iBudget to pay for support and services.

(e) The service limitations in subparagraphs (3)(f)1., 2., and 3. shall not apply to the iBudget system.

(f) Rates for any or all services established under rules of the agency shall be designated as the maximum rather than a fixed amount for individuals who receive an iBudget, except for services specifically identified in those rules that the agency determines are not appropriate for negotiation, which may include, but are not limited to, residential habilitation services.

(g) The agency shall ensure that clients and caregivers in the demonstration project area have access to training and education to inform them about the iBudget system and enhance their ability for self-direction. Such training shall be offered in a variety of formats and, at a minimum, shall address the policies and processes of the iBudget system; the roles and responsibilities of consumers, caregivers, waiver support coordinators, providers, and the agency; information available to help the client make decisions regarding the iBudget system; and examples of support and resources available in the community.

(h)1. The agency, in consultation with the Agency for Health Care Administration, shall prepare a design plan for the purchase of an evaluation by an independent contractor. The design plan to evaluate the iBudget demonstration project shall be submitted to the President of the Senate and the Speaker of the House of Representatives for approval not later than December 31, 2010.

2. The agency shall prepare an evaluation that shall include, at a minimum, an analysis of cost savings, cost containment, and budget predictability. In addition, the evaluation shall review the demonstration with regard to consumer education, quality of care, affects on choice of and access to services, and satisfaction of demonstration project participants. The agency shall submit the evaluation report to the Governor, the President of the Senate, and the Speaker of the House of Representatives no later than December 31, 2013.

(i) The agency shall adopt rules specifying the allocation algorithm and methodology; criteria and processes for clients to access reserved funds for extraordinary needs, temporarily or permanently changed needs, and one-time needs; and processes and requirements for selection and review of services, development of support and cost plans, and management of the iBudget system as needed to administer this subsection.

(10) The agency shall develop a transition plan for recipients who are receiving services in one of the four waiver tiers at the time qualified plans are available in each recipient's region pursuant to s. 409.989(3) to enroll those recipients in qualified plans.

(11) This section expires October 1, 2015.

T I T L E A M E N D M E N T

Between lines 4 and 5, insert:

providing for an establishment of an iBudget demonstration project by the Agency for Persons with Disabilities, in consultation with the Agency for Health Care Administration, in specified counties; providing for allocation of funds; providing goals; providing for an allocation algorithm and methodology for development of a client's iBudget; providing for the seeking of federal approval and waivers; providing for a transition to full implementation; providing for inapplicability of certain service limitations; providing for setting rates; providing for client training and education; providing for evaluation; requiring a report; requiring rulemaking;

Rep. Aubuchon moved the adoption of the amendment, which was adopted.

Representative Grimsley offered the following:

(Amendment Bar Code: 937479)

Amendment 2 (with title amendment)—Remove lines 480-506 and insert:

(d) May enroll entities as Medicare crossover-only providers for payment and claims processing purposes only. The provider agreement shall:

1. Require that the provider is an eligible Medicare provider, has a current provider agreement in place with the Centers for Medicare and Medicaid Services, and provides verification that the provider is currently in good standing with the agency.

2. Require that the provider notify the agency immediately, in writing, upon being suspended or disenrolled as a Medicare provider. If a provider does not provide such notification within 5 business days after suspension or disenrollment, sanctions may be imposed pursuant to this chapter and the provider may be required to return funds paid to the provider during the period of time that the provider was suspended or disenrolled as a Medicare provider.

3. Require that all records pertaining to health care services provided to each of the provider's recipients be kept for a minimum of 5 years. The agreement shall also require that records and information relating to payments claimed by the provider for services under the agreement be delivered to the agency or the Office of the Attorney General Medicaid Fraud Control Unit when requested. If a provider does not provide such records and information when requested, sanctions may be imposed pursuant to this chapter.

4. Disclose that the agreement is for the purposes of paying and processing Medicare crossover claims only.

T I T L E A M E N D M E N T

Remove line 24 and insert:
crossover-only providers for payment and claims processing purposes only;

Rep. Grimsley moved the adoption of the amendment, which was adopted.

Representative Grimsley offered the following:

(Amendment Bar Code: 318509)

Amendment 3 (with title amendment)—Remove lines 815-818 and insert:
system and who reside in AHCA area 10 shall be enrolled in capitated managed care plans that, in coordination with available community-based care providers specified in s. 409.1671, provide sufficient medical, developmental, behavioral and emotional services to meet the needs of these children. ~~are exempt from the specialty prepaid plan upon the development of a service delivery mechanism for children who reside in area 10 as specified in s. 409.91211(3)(dd).~~

T I T L E A M E N D M E N T

Remove line 35 and insert:
Medicaid managed care; requiring Medicaid-eligible children with open child welfare cases who reside in AHCA area 10 to be enrolled in specified capitated managed care plans; eliminating obsolete provisions and

Rep. Grimsley moved the adoption of the amendment, which was adopted.

On motion by Rep. Homan, by the required two-thirds vote, the House agreed to consider the following late-filed amendment.

Representative Homan offered the following:

(Amendment Bar Code: 304175)

Amendment 4—Remove lines 2453-2454 and insert:

6. Paying primary care providers. It is the intent of the Legislature that the savings that result from the implementation of the medical home network model be used to enable Medicaid fees to physicians participating in medical home networks to be equivalent to 100 percent of Medicare rates as soon as possible.

Rep. Homan moved the adoption of the amendment, which was adopted.

Representative Grimsley offered the following:

(Amendment Bar Code: 436503)

Amendment 5 (with title amendment)—Remove line 2118 and insert:
(40)~~(43)~~ The agency shall ~~may~~ contract on a prepaid or fixed-sum

---

T I T L E A M E N D M E N T

Remove line 35 and insert:
Medicaid managed care; requiring the Agency for Health Care Administration to contract on a prepaid or fixed-sum basis with certain prepaid dental health plans; eliminating obsolete provisions and

Rep. Grimsley moved the adoption of the amendment, which was adopted.

Representative Grimsley offered the following:

(Amendment Bar Code: 570143)

Amendment 6 (with title amendment)—Remove lines 2650-2659 and insert:
average for all plans. Except as otherwise provided in this paragraph, the risk adjusted capitation rates shall be phased in as follows:

1. In the first fiscal year, 75 percent of the capitation rate shall be based on the current methodology and 25 percent shall be based on the risk-adjusted rate methodology.

2. In the second fiscal year, 50 percent of the capitation rate shall be based on the current methodology and 50 percent shall be based on the risk-adjusted methodology.

3. In the third fiscal year, the risk-adjusted capitation methodology shall be fully implemented.

The rates for plans owned and operated by a public hospital shall be risk-adjusted immediately. In order to meet the requirements of budget neutrality, and until such time as all rates in the county are risk-adjusted, the rate differential is contingent on the nonfederal share being provided through grants and donations from allowable nonstate sources. The agency shall submit an amendment to the Legislative Budget Commission requesting authority for such payments.

T I T L E A M E N D M E N T

Remove line 91 and insert:
phased schedule for risk-adjusted capitation rates; providing for immediate risk adjustment of rates for plans owned and operated by a public hospital in the county; providing a method to ensure budget neutrality until all rates in the county are risk-adjusted; requiring the agency to submit an amendment to the Legislative Budget Commission requesting authority for payments;

Rep. Grimsley moved the adoption of the amendment, which was adopted.

On motion by Rep. Jones, by the required two-thirds vote, the House agreed to consider the following late-filed amendment.

Representative Jones offered the following:

(Amendment Bar Code: 054651)

Amendment 7 (with title amendment)—Remove line 2700 and insert:
costs per enrollee. The agency shall establish an initiative to improve recipient access to information about plan performance. The agency shall publish on its Internet website information on plan performance, including, but not limited to, results of plan enrollee satisfaction surveys, data reported pursuant to s. 409.9122(17), and information on recipient grievances. The website shall be user-friendly and shall provide an opportunity for recipients to give web-based

feedback on plans. Plans shall advise recipients of the information available on the agency's website and how to access it in the initial enrollment materials. The agency shall evaluate the initiative to determine whether it improves recipient access to information.

T I T L E A M E N D M E N T

Remove line 97 and insert:
University of Florida for evaluation of the pilot program; requiring the agency to establish a specified initiative and publish certain information;

Rep. Jones moved the adoption of the amendment, which was adopted.

On motion by Rep. Fitzgerald, by the required two-thirds vote, the House agreed to consider the following late-filed amendment.

Representative Fitzgerald offered the following:

(Amendment Bar Code: 362273)

Amendment 8 (with title amendment)—Remove line 3204 and insert:
the data submitted by the plans. Prior to utilizing validated encounter data to adjust rates for prepaid plans, the agency shall conduct a review to ensure adequate encounter data is available to establish actuarially sound rates. The review shall include a simulated rate-setting exercise, followed by an evaluation by independent actuaries and consideration of comments from the plans. The agency shall publish the results of the review on its website at least 30 days prior to adjusting rates.

T I T L E A M E N D M E N T

Remove line 121 and insert:
System; requiring the agency to conduct a review of encounter data and publish the results of the review prior to adjusting rates for prepaid plans; requiring the agency to establish a designated

Rep. Fitzgerald moved the adoption of the amendment, which was adopted.

Under Rule 10.10(b), the bill was referred to the Engrossing Clerk.

Immediately Certified

On motion by Rep. Galvano, the rules were waived and **CS for CS for SB 350**, **CS/HB 451**, **CS/HB 569**, **CS/HB 1225**, **CS/CS/HB 747**, **CS/HB 1101**, **CS/HB 1281**, **CS/HB 143**, **CS/HB 1291**, **CS/HB 7099**, **CS/HB 109**, **HB 7153**, and **CS/CS/HB 119**, which passed the House today, were immediately certified to the Senate.

Motion to Adjourn

Rep. Cannon moved that the House, after receiving reports, adjourn for the purpose of holding council and committee meetings and conducting other House business, to reconvene at 12:30 p.m., Monday, April 19, 2010, or upon call of the Chair. The motion was agreed to.

Messages from the Senate

The Honorable Larry Cretul, Speaker

I am directed to inform the House of Representatives that the Senate has passed CS for HB 295.

R. Philip Twogood, Secretary

The above bill was ordered enrolled.

The Honorable Larry Cretul, Speaker

I am directed to inform the House of Representatives that the Senate has adopted SCR 10 and requests the concurrence of the House.

R. Philip Twogood, Secretary

By Senators Atwater, Gaetz, Jones, Bennett, Haridopolos, Altman, Baker, Alexander, Thrasher, Gardiner, Negron, Oelrich, and Richter—

SCR 10—A concurrent resolution urging Congress to call a convention for the purpose of proposing amendments to the Constitution of the United States to provide for a balanced federal budget and limit the ability of Congress to dictate to states requirements for the expenditure of federal funds.

First reading by publication (Art. III, s. 7, Florida Constitution).

Referred to the Rules & Calendar Council.

The Honorable Larry Cretul, Speaker

I am directed to inform the House of Representatives that the Senate has passed CS for SB 622, as amended, and requests the concurrence of the House.

R. Philip Twogood, Secretary

By the Committee on Regulated Industries; and Senator Jones—

CS/SB 622—A bill to be entitled An act relating to gaming; amending s. 285.710, F.S., relating to compact authorization; providing definitions; providing that specified agreements executed by the Seminole Tribe of Florida and the Governor are void and not in effect; ratifying and approving a specified compact executed by the Tribe and the Governor; directing the Governor to cooperate with the Tribe in seeking approval of the compact from the United States Secretary of the Interior; revising powers and duties of the Governor regarding a compact and amendments to a compact between the Tribe and the state; revising a provision that specifies that the compact is invalid if certain provisions are held invalid by a court or the United States Department of the Interior; revising a provision for the effect on the compact of certain changes to the Indian Gaming Regulatory Act; removing a provision directing the Governor to ensure certain funds received are deposited in a specified fund; removing a provision for expiration of certain authority granted to the Governor; removing a provision that expresses legislative intent; revising duties of the Governor to execute an agreement for application of certain state taxes on Indian lands; providing for distribution of certain moneys paid to the state; providing for the calculation and distribution of a local government share of such moneys; revising provisions for moneys remitted by the Tribe to the state before the effective date of the compact; providing for deposit of the moneys into the General Revenue Fund; revising provisions that authorize certain gaming activity; repealing s. 285.711, F.S., relating to a gaming compact between the Seminole Tribe and the State of Florida; creating s. 285.712, F.S.; providing that the Governor is the designated state officer responsible for negotiating and executing, on behalf of the state, tribal-state gaming compacts with certain Indian tribes; requiring any such compact to be conditioned on ratification by the Legislature; providing procedures for ratification of a compact and submission to the United States Secretary of the Interior for review and approval; amending s. 26 of chapter 2009-170, Laws of Florida, an act relating to gaming; revising the effective date for provisions of that act to remove contingency requirements applicable to provisions relating to the pari-mutuel industry; providing a date for those provisions to take effect; providing an effective date.

First reading by publication (Art. III, s. 7, Florida Constitution).

Referred to the Calendar of the House.

The Honorable Larry Cretul, Speaker

I am directed to inform the House of Representatives that the Senate has passed CS for SB 2060, and requests the concurrence of the House.

R. Philip Twogood, Secretary

By the Committee on Judiciary; and Senator Bennett—

CS/SB 2060—A bill to be entitled An act relating to sovereign immunity; amending s. 768.28, F.S.; increasing the statutory limits on liability for tort claims against the state and its agencies and subdivisions; providing for application of the act to claims arising on or after the effective date; providing an effective date.

First reading by publication (Art. III, s. 7, Florida Constitution).

Referred to the Calendar of the House.

The Honorable Larry Cretul, Speaker

I am directed to inform the House of Representatives that the Senate has passed CS for SB 2440, and requests the concurrence of the House.

R. Philip Twogood, Secretary

By the Committee on Judiciary; and Senator Bennett—

CS/SB 2440—A bill to be entitled An act relating to liability releases; amending s. 549.09, F.S.; redefining the term "nonspectators" to include a minor on whose behalf a natural guardian has signed a motorsport liability release; providing that a motorsport liability release signed by a natural guardian on behalf of a minor participating in a sanctioned motorsports event is valid to the same extent as for other nonspectators; limiting the validity of a waiver or release signed by a natural guardian on behalf of a minor participating in an activity at a closed-course motorsport facility other than a sanctioned motorsports event; amending s. 744.301, F.S.; authorizing natural guardians to waive, in advance, claims for injuries arising from risks inherent in a commercial activity; defining the term "inherent risk"; providing a statement that must be included in the waiver; creating a rebuttable presumption that a waiver is valid and that the injury arose from the inherent risk; providing the requirements and standard of evidence for overcoming the presumption; authorizing natural guardians to waive, in advance, any claim against a noncommercial provider to the extent allowed by common law; providing an effective date.

First reading by publication (Art. III, s. 7, Florida Constitution).

Referred to the Calendar of the House.

Votes After Roll Call

[Date(s) of Vote(s) and Sequence Number(s)]

Rep. Horner:

Yeas—March 24: 617, 618, 619, 620

Nays—March 18: 584

Rep. Randolph:

Yeas—March 24: 624; March 31: 636; April 6: 689

Nays—March 31: 634

Yeas to Nays—April 7: 689

Rep. Y. Roberson:

Yeas—March 18: 576, 577, 578, 579

Nays—March 18: 580, 581

Yeas to Nays—March 18: 578

Nays to Yeas—March 18: 578

Rep. T. Williams:

Nays—April 7: 706

First-named Sponsors

CS/HB 1565—Gaetz

HR 9101—Robaina

Cosponsors

HB 7—Thurston

CS/HJR 37—Gaetz

CS/CS/HB 119—Adkins, Burgin, Carroll

CS/HB 289—Soto

CS/HB 325—Pafford, K. Roberson

HB 387—Ambler, Brandenburg, Carroll, Fetterman, Fitzgerald, Gibson, Hays, Heller, Homan, Jones, Kriseman, Long, Planas, Proctor, Randolph, Robaina, Sachs, Sands, Saunders, Schwartz, Soto, Thurston, Tobia, Waldman

CS/HB 1009—Schenck

HM 1349—Sands

CS/HJR 1399—Tobia

HB 1485—Kriseman

HB 1629—Kriseman

HR 9033—Bembry, Bovo, Sands

Withdrawals as Cosponsor

CS/HJR 1399—Rouson

Introduction and Reference

By the Select Policy Council on Strategic & Economic Planning; Representative Carroll—

HB 7227—A bill to be entitled An act relating to the Legislature; fixing the date for convening the regular session of the Legislature in the year 2012; providing an effective date.

First reading by publication (Art. III, s. 7, Florida Constitution).

By the Energy & Utilities Policy Committee; Representative Precourt—

HB 7229—A bill to be entitled An act relating to economic incentives for energy initiatives; amending s. 377.601, F.S.; revising legislative intent relating to the state's energy policy; amending s. 377.703, F.S.; conforming cross-references; amending s. 212.08, F.S.; providing definitions; providing sales and use tax exemptions for electric-powered automobiles, natural gas

vehicles, and fueling stations for such automobiles and vehicles; extending the sales and use tax exemptions for certain renewable energy technologies; amending s. 220.192, F.S.; extending the renewable energy technologies investment tax credit and applying the credit to certain investments in solar energy systems; defining the term "solar energy system"; revising the eligible cost limit for investments in biodiesel and ethanol; transferring certain duties relating to such tax credits from the Department of Environmental Protection to the Florida Energy and Climate Commission; amending s. 220.193, F.S.; extending the renewable energy production credit; amending s. 366.02, F.S.; revising the definition of the term "public utility" for purposes of regulating such utilities; creating s. 366.90, F.S.; providing legislative intent relating to renewable energy production of electricity; amending s. 366.91, F.S.; deleting legislative intent provisions to conform to changes made by the act; revising definitions of the terms "biomass" and "renewable energy"; requiring public utilities to purchase renewable energy from producers at full avoided cost under certain circumstances; providing that renewable energy producers are entitled to sell electrical energy to a public utility at full avoided cost under certain circumstances; providing legislative findings; providing for the calculation of full avoided cost for such purchases of renewable energy; declaring that certain actions taken by the Public Service Commission are not actions relating to utility rates or services; amending s. 366.92, F.S.; deleting the legislative intent provisions; deleting and revising definitions; deleting provisions for the renewable portfolio standard and renewable energy credits; providing a mechanism for providers to recover costs to produce or purchase specified amounts of renewable energy through the environmental cost-recovery clause under certain conditions; requiring providers to include specified information related to renewable energy development in a certain report; authorizing a developer of solar energy generation to locate a solar energy generation facility on the premises of a host consumer under certain circumstances; requiring the commission to adopt rules and submit reports to the Legislature; amending s. 403.503, F.S.; revising the definition of "electrical power plant" for purposes of the Florida Electrical Power Plant Siting Act; amending ss. 288.9602 and 288.9603, F.S.; revising legislative findings and declarations and definitions for purposes of the Florida Development Finance Corporation Act; amending s. 288.9604, F.S.; revising requirements for the establishment and organization of the Florida Development Finance Corporation; amending s. 288.9605, F.S.; revising the powers of the corporation; amending s. 288.9606, F.S.; revising requirements for the corporation's issuance of revenue bonds; amending s. 288.9607, F.S.; limiting the corporation's approval of guaranties for debt service for bonds or other indebtedness for any one capital project; deleting provisions for the corporation's investment of certain funds in the State Transportation Trust Fund; authorizing guarantees to be used in conjunction with federal guaranty programs; amending s. 288.9608, F.S.; creating the Energy, Technology, and Economic Development Guaranty Fund; providing for the deposit of certain moneys in the fund; deleting requirements for the corporation's debt service reserve account and Revenue Bond Guaranty Reserve Account; amending ss. 288.9609, 288.9610, 206.46, 215.47, 339.08, and 339.135, F.S.; conforming provisions to changes made by the act; providing for severability; providing an effective date.

First reading by publication (Art. III, s. 7, Florida Constitution).

By Representative Saunders—

HR 9103—A resolution recognizing April 20, 2010, as "Florida Keys Day" in Tallahassee.

First reading by publication (Art. III, s. 7, Florida Constitution).

By Representative Evers—

HR 9105—A resolution recognizing and commending the individuals, foundations, and corporate givers of the state for their charitable acts that enrich the quality of life of all Floridians.

First reading by publication (Art. III, s. 7, Florida Constitution).

By Representative Sachs—

HR 9107—A resolution honoring Florida's athletes for their athletic endeavors, commending the Governor's Council on Physical Fitness for its leadership, and recognizing Chris Evert for her contributions in promoting physical fitness.

First reading by publication (Art. III, s. 7, Florida Constitution).

By Representative A. Williams—

HR 9109—A resolution honoring Andre Dawson in the year of his induction into the Baseball Hall of Fame.

First reading by publication (Art. III, s. 7, Florida Constitution).

By Representative Fetterman—

HR 9111—A resolution recognizing the students, faculty, staff, alumni, and Board of Trustees of Indian River State College as they celebrate "50 Years of Innovation" as an institution of higher learning in Florida.

First reading by publication (Art. III, s. 7, Florida Constitution).

By Representative Reagan—

HR 9113—A resolution designating May 13, 2010, as "Florida Employer Support of the Guard and Reserve Day."

First reading by publication (Art. III, s. 7, Florida Constitution).

By Representative Hays—

HR 9115—A resolution recognizing Jimmie Johnson for his achievements in the sport of stock car racing and for his humanitarian efforts through the Jimmie Johnson Foundation.

First reading by publication (Art. III, s. 7, Florida Constitution).

By Representative Holder—

HR 9117—A resolution recognizing the 2009 Tallahassee-Leon County 13-Year-Old and 15-Year-Old All-Star teams for winning Babe Ruth Baseball World Series Championships.

First reading by publication (Art. III, s. 7, Florida Constitution).

By Representative Zapata—

HR 9119—A resolution recognizing the students, faculty, staff, board of trustees, and alumni of Miami Dade College as they celebrate the college's 50 years as an outstanding institution of higher education.

First reading by publication (Art. III, s. 7, Florida Constitution).

By Representative Zapata—

HR 9121—A resolution recognizing Pedro J. Greer, Jr., M.D., as an outstanding humanitarian, physician, professor, and author.

First reading by publication (Art. III, s. 7, Florida Constitution).

By Representative Zapata—

HR 9123—A resolution recognizing Leslie V. Pantín, Jr., for his valuable contributions to the residents of the State of Florida and honoring him as one of Florida's great innovators.

First reading by publication (Art. III, s. 7, Florida Constitution).

By Representative Garcia—

HR 9125—A resolution designating April 21-22, 2010, as "Miami-Dade County Days" at the Capitol.

First reading by publication (Art. III, s. 7, Florida Constitution).

By Representative Ray—

HR 9127—A resolution recognizing the Boy Scouts of America on the occasion of its 100th anniversary.

First reading by publication (Art. III, s. 7, Florida Constitution).

By Representative Reagan—

HR 9129—A resolution recognizing June 2010 as "Recreational Vehicle and Camping Month" in Florida.

First reading by publication (Art. III, s. 7, Florida Constitution).

By Representative Glorioso—

HR 9131—A resolution recognizing Florida's vineyards and wineries for their valuable contributions to Florida's rich history, culture, and economy.

First reading by publication (Art. III, s. 7, Florida Constitution).

By Representative Y. Roberson—

HR 9133—A resolution observing May 25, 2010, as "National Missing Children's Day" in Florida.

First reading by publication (Art. III, s. 7, Florida Constitution).

By Representative A. Williams—

HR 9135—A resolution recognizing Emmitt James Smith III for his selection as a member of the Pro Football Hall of Fame.

First reading by publication (Art. III, s. 7, Florida Constitution).

First Reading of Council and Committee Substitutes by Publication

By the General Government Policy Council; Finance & Tax Council; and Insurance, Business & Financial Affairs Policy Committee; Representatives Legg and Nehr—

CS/CS/CS/HB 159—A bill to be entitled An act relating to guaranty associations; amending s. 631.52, F.S.; expanding an exemption from the applicability of certain provisions of state law to include workers' compensation claims under employer liability coverage; amending s. 631.54, F.S.; conforming the definition of "account" to changes made by the act; amending s. 631.55, F.S.; revising the separate accounts of the association; amending s. 631.57, F.S.; conforming cross-references; providing a legislative finding and declaration; authorizing insurers to recoup certain assessments levied by the Office of Insurance Regulation by applying certain recoupment factors; deleting provisions relating to classification and payment of emergency assessments; providing guidelines and a methodology for the calculation of recoupment factors for recouping certain assessments; authorizing an insurer to apply a recalculated recoupment factor under certain conditions; providing for the return of excess assessments and recoupment charges; providing that amounts recouped are not premium and not subject to premium taxes, fees, or commissions; requiring that insurers treat failure to pay a recoupment charge as failure to pay the premium; requiring that an insurer file with the office a statement containing certain information within a specified period before applying a recoupment factor to any policies; authorizing an insurer to use a recoupment factor after the expiration of such period; providing that an insurer need submit only one such statement for all lines of business; requiring that an insurer file with the office an accounting report containing certain information within a specified period after the completion of the recoupment process; providing that an insurer need submit only one such report for all lines of business; amending s. 631.713, F.S.; expanding the application of certain provisions of state law to certain residents of other states who own certain insurance policies; expanding the list of contracts and policies to which life and health insurance guaranty of payments provisions do not apply; providing for application to coverage under certain structured settlement annuities under certain circumstances; amending s. 631.714, F.S.; revising certain definitions; amending s. 631.717, F.S.; revising a guaranty association's aggregate liability for life insurance and deferred annuity contracts; authorizing an association to issue alternative policies or contracts to certain policies or contracts under certain circumstances; subjecting such alternative policies or contracts to specified requirements; creating s. 631.7295, F.S.; authorizing an association to succeed to the rights of an insolvent insurer arising after an order of liquidation or rehabilitation with regard to certain contracts of reinsurance; requiring that such an association pay all unpaid premiums due under the contract; amending s. 631.735, F.S.; specifying that certain advertisement prohibitions do not prohibit the furnishing of certain written information in a form prepared by an association upon request; amending s. 631.904, F.S.; revising the definition of the term "covered claim"; providing an effective date.

First reading by publication (Art. III, s. 7, Florida Constitution).

By the Criminal & Civil Justice Policy Council; and Finance & Tax Council; Representatives Rouson, Abruzzo, Bernard, Heller, and Nehr—

CS/CS/HB 187—A bill to be entitled An act relating to retail sales of smoking pipes and smoking devices; creating s. 569.0073, F.S.; prohibiting retail sales of certain smoking pipes and smoking devices under certain circumstances; specifying criteria for the lawful sales of such items; providing a criminal penalty for unlawful sales of such items; providing an effective date.

First reading by publication (Art. III, s. 7, Florida Constitution).

By the General Government Policy Council; Government Operations Appropriations Committee; and Insurance, Business & Financial Affairs Policy Committee; Representatives Hudson and Burgin—

CS/CS/CS/HB 311—A bill to be entitled An act relating to debt settlement services; providing a directive to the Division of Statutory Revision; creating s. 559.101, F.S.; providing a short title; creating s. 559.102, F.S.; providing definitions; creating s. 559.103, F.S.; providing the powers of the Office of Financial Regulation; creating s. 559.104, F.S.; authorizing the Financial Services Commission to adopt rules; creating s. 559.105, F.S.; providing exceptions from the applicability of provisions regulating debt settlement services; providing an exception for attorneys representing clients; creating s. 559.106, F.S.; requiring debt settlement organizations to be registered with the office; providing a registration fee; requiring background screening of applicants and control persons; providing grounds for registration issuance or denial; requiring annual renewal; creating s. 559.107, F.S.; requiring registration renewal; creating s. 559.108, F.S.; requiring a debt settlement organization to obtain certain insurance coverage and a surety bond and to provide proof of such bond to the office; creating s. 559.109, F.S.; requiring a debt settlement organization to maintain records; creating s. 559.111, F.S.; requiring a debt settlement organization to prepare a financial analysis for the debtor; providing for service contracts; requiring certain provisions to be included in such contracts; requiring the debt settlement organization to provide the debtor with copies of all signed documents; creating s. 559.112, F.S.; prohibiting certain acts by debt settlement organizations; providing penalties; creating s. 559.113, F.S.; providing for debtor complaints to the office; providing procedures and office duties, including administrative penalties; creating s. 559.114, F.S.; providing for the issuance of subpoenas by the office; creating s. 559.115, F.S.; authorizing the office to issue cease

and desist orders; creating s. 559.116, F.S.; declaring that violations of the part are deceptive and unfair trade practices; providing administrative penalties; specifying violations that result in criminal penalties; amending s. 516.07, F.S.; conforming a cross-reference; repealing ss. 559.10, 559.11, 559.12, and 559.13, F.S., relating to budget planning; providing an appropriation and authorizing additional positions; providing effective dates.

First reading by publication (Art. III, s. 7, Florida Constitution).

By the Finance & Tax Council; and Military & Local Affairs Policy Committee; Representative Pafford—

CS/CS/HB 1095—A bill to be entitled An act relating to special districts; amending s. 189.4042, F.S.; revising provisions relating to merger and dissolution procedures for special districts; requiring certain merger and dissolution procedures to include referenda; providing that such provisions preempt prior special acts; providing an exception; providing for a local government to assume the indebtedness of, and receive the title to property owned by, a special district under certain circumstances; amending s. 189.4044, F.S.; revising dissolution procedures for special districts declared inactive by a governing body; repealing s. 191.014(3), F.S., relating to the conditions under which the merger of independent special fire control districts with other special districts is effective and the conditions under which a merged district is authorized to increase ad valorem taxes; providing an effective date.

First reading by publication (Art. III, s. 7, Florida Constitution).

By the PreK-12 Appropriations Committee; and PreK-12 Policy Committee; Representatives Grady and Stargel—

CS/CS/HB 1287—A bill to be entitled An act relating to education; providing a short title; amending s. 1011.62, F.S.; requiring that each school district allocate 100 percent of the funds received for instruction for the International Baccalaureate Program, Advanced International Certificate of Education, and the Advanced Placement Program; requiring that such funds be expended solely for administrative costs associated with such programs and teachers' bonuses; revising provisions relating to the distribution of bonuses for teachers who provide instruction to such programs; amending s. 1007.35, F.S.; revising provisions relating to the duties of the Florida Partnership for Minority and Underrepresented Student Achievement; requiring that the partnership, in cooperation with the Department of Education, post an annual report on the department's website regarding the Advanced Placement Program; specifying the information that such report must contain; providing an effective date.

First reading by publication (Art. III, s. 7, Florida Constitution).

By the General Government Policy Council; and Full Appropriations Council on Education & Economic Development; Representative Horner—

CS/CS/HB 1299—A bill to be entitled An act relating to streamlining the issuance of licenses, certifications, and registrations issued by state agencies; providing a short title; providing legislative findings and intent; requiring the Governor to establish the One-Stop Business Workgroup; providing for the membership of the workgroup; authorizing the workgroup to consult with other agencies and use consultants; providing duties of the workgroup; requiring that the workgroup submit a plan for establishing a business licensing portal to the Governor and Legislature by a specified date; providing requirements for the plan to implement a technology solution that provides businesses and individuals with easy access to state and local requirements for business licenses, certifications, and registrations; providing an effective date.

First reading by publication (Art. III, s. 7, Florida Constitution).

By the General Government Policy Council; and Natural Resources Appropriations Committee; Representative Poppell—

CS/CS/HB 1385—A bill to be entitled An act relating to petroleum contamination site cleanup; amending s. 376.3071, F.S.; revising provisions relating to petroleum contamination site selection and cleanup criteria; deleting obsolete provisions relating to funding for limited interim soil-source removals; requiring the Department of Environmental Protection to utilize natural attenuation monitoring strategies to transition sites into long-term natural attenuation monitoring under specified conditions; providing for natural attenuation and active remediation of sites; requiring the department to evaluate certain costs and strategies; prohibiting local governments from denying building permits under specified conditions; providing requirements for such permits and related construction, repairs, and renovations; establishing a low-scored site initiative; providing conditions for participation; requiring the department to issue certain determinations and orders; providing that certain sites are eligible for payment of preapproved costs; requiring assessment work to be completed within a certain timeframe; providing payment and funding limitations; deleting provisions relating to nonreimbursable voluntary cleanup; requiring the installation of fuel tank upgrades to secondary containment systems to be completed by specified deadlines; providing an exception; providing an effective date.

First reading by publication (Art. III, s. 7, Florida Constitution).

By the Criminal & Civil Justice Policy Council; Representatives Stargel, Ambler, Bovo, Burgin, Bush, Crisafulli, Flores, Ford, Fresen, Gonzalez, Kelly, Kreegel, Mayfield, McKeel, Murzin, Plakon, Planas, Robaina, Snyder, Tobia, Van Zant, Weatherford, Weinstein, T. Williams, Workman, and Zapata—

CS/HB 1449—A bill to be entitled An act relating to parental notice of abortion; amending s. 390.01114, F.S.; revising the definition of the term "constructive notice"; revising notice requirements relating to the termination of a pregnancy of a minor; providing exceptions to the notice requirements; revising procedure for judicial waiver of notice; providing for the minor to petition for a hearing within a specified time; providing that in a hearing relating to waiving the requirement for parental notice the court consider certain additional factors, including whether the minor's decision to terminate her pregnancy was due to undue influence; providing procedure for appeal if judicial waiver of notice is not granted; requiring Supreme Court reports to the Governor and Legislature to include additional information; requiring mandatory reporting of child abuse; providing for severability; providing an effective date.

First reading by publication (Art. III, s. 7, Florida Constitution).

By the Criminal & Civil Justice Policy Council; and Public Safety & Domestic Security Policy Committee; Representatives Ambler, Brisé, A. Williams, and Zapata—

CS/HB 7181—A bill to be entitled An act relating to juvenile justice; amending s. 394.492, F.S.; including children 9 years of age or younger at the time of referral for a delinquent act within the definition of those children who are eligible to receive comprehensive mental health services; amending s. 984.03, F.S.; expanding the meaning of the terms "child in need of services" and "family in need of services" to include a child 9 years of age or younger at the time of referral to the Department of Juvenile Justice; amending s. 984.14, F.S.; providing for a youth taken into custody for a misdemeanor domestic violence charge who is ineligible to be held in secure detention to be placed in a shelter; amending s. 985.02, F.S.; providing additional legislative findings and intent concerning very young children and restorative justice; amending s. 985.03, F.S.; expanding the meaning of the terms "child in need of services" and "family in need of services" to include a child 9 years of age or younger at the time of referral to the Department of Juvenile Justice; amending s. 985.125, F.S.; encouraging law enforcement agencies, school districts, counties, municipalities, and the Department of Juvenile Justice to establish prearrest or postarrest diversion programs for youth; providing that youth

who are taken into custody for first-time misdemeanor offenses or offenders who are 9 years of age or younger should have an opportunity to participate in such programs; amending s. 985.145, F.S.; requiring a juvenile probation officer to refer a child to the appropriate shelter if the completed risk assessment instrument shows that the child is ineligible for secure detention; amending s. 985.24, F.S.; prohibiting a child alleged to have committed a delinquent act or violation of law from being placed into secure, nonsecure, or home detention care because of a misdemeanor charge of domestic violence if the child lives in a family that has a history of domestic violence or if the child is a victim of abuse or neglect; prohibiting a child 9 years of age or younger from being placed into secure detention care unless the child is charged with a capital felony, life felony, or felony of the first degree; amending s. 985.245, F.S.; revising membership on the statewide risk assessment instrument committee; amending s. 985.255, F.S.; providing that a child may be retained in home detention care under certain circumstances; providing that a child who is charged with committing a felony offense of domestic violence and who does not meet detention criteria may nevertheless be held in secure detention if the court makes certain specific written findings; amending s. 985.441, F.S.; providing that a court may commit a female child adjudicated as delinquent to the department for placement in a mother-infant program designed to serve the needs of the juvenile mothers or expectant juvenile mothers who are committed as delinquents; requiring the department to adopt rules to govern the operation of the mother-infant program; amending s. 985.45, F.S.; specifying that a child working under certain circumstances is a state employee for workers' compensation purposes; amending s. 985.632, F.S.; revising provisions relating to quality assurance and cost-effectiveness of department programs; amending s. 985.664, F.S.; increasing the number of members by which a juvenile justice circuit board may be increased to reflect the diversity of the population and community organizations or agencies in the circuit; providing legislative findings concerning the determination of whether to commit a juvenile to the Department of Juvenile Justice and to determine the most appropriate restrictiveness level for such a juvenile; providing an effective date.

First reading by publication (Art. III, s. 7, Florida Constitution).

By the General Government Policy Council; Full Appropriations Council on Education & Economic Development; and Energy & Utilities Policy Committee; Representative Precourt—

CS/CS/HB 7209—A bill to be entitled An act relating to reorganization of the Public Service Commission; amending s. 20.121, F.S.; establishing the Office of Regulatory Staff within the Financial Services Commission; requiring the executive director of the Office of Regulatory Staff to meet specified requirements; providing that the executive director's appointment is subject to Senate confirmation; amending s. 112.324, F.S.; revising provisions for disposition of ethics complaints against the Public Counsel and employees of the Public Counsel; amending s. 186.801, F.S.; directing the commission to request assistance from the Office of Regulatory Staff to make a preliminary study of certain site plans submitted to the commission by electric utilities; amending s. 350.001, F.S.; revising legislative intent; amending s. 350.011, F.S.; prohibiting certain acts by commissioners and commission staff; repealing s. 350.012, F.S., relating to the creation and organization of the Committee on Public Counsel Oversight; amending s. 350.031, F.S.; revising requirements for nomination by the Public Service Commission Nominating Council for appointment to the commission; requiring at least one commissioner to be a certified accountant practicing in the state; creating s. 350.035, F.S.; prohibiting attempts by certain persons to sway the judgment of commissioners; providing for the Commission on Ethics to investigate complaints of violations pursuant to specified procedures; amending s. 350.04, F.S.; providing requirements for nomination by the Public Service Commission Nominating Council for appointment to the commission; requiring commissioners to complete a course of study developed by the executive director and general counsel of the Office of Regulatory Staff; requiring commissioners to complete continuing education; providing training requirements for commissioners and commission employees; requiring certifications of compliance to be provided to the Legislature; amending s. 350.041, F.S.; revising legislative intent; revising standards of conduct for commissioners; revising provisions for investigation and reports by the Commission on Ethics of alleged violations; authorizing commission employees and the executive director of the Office of Regulatory Staff to request opinions from the Commission on Ethics; amending s. 350.042, F.S.; revising provisions for communications concerning agency action proceedings and proceedings under specified provisions; providing for application of such provisions to commission employees; revising restrictions on such communications by commissioners and commission employees; defining the term "ex parte communication"; providing a civil penalty; amending s. 350.06, F.S.; revising provisions for the offices of the commission, payment of moneys, and employment of personnel; amending s. 350.0605, F.S.; restricting employment of a former executive director or former employee of the Office of Regulatory Staff; amending s. 350.061, F.S.; providing for appointment of the Public Counsel by, and service of the Public Counsel at the pleasure of, the Attorney General; amending ss. 350.0613 and 350.0614, F.S.; providing powers and duties of the Attorney General regarding the Public Counsel and his or her employees to conform provisions to the transfer of the Public Counsel; transferring the Office of Public Counsel from the legislative branch to the Office of the Attorney General; creating s. 350.071, F.S.; creating the Office of Regulatory Staff within the Financial Services Commission; providing for the office to be considered a party of record in all proceedings before the Public Service Commission; requiring the commission to notify the office of certain proceedings; providing purpose of the office; defining the term "public interest"; providing that the office is subject to certain provisions governing ex parte communications; creating s. 350.072, F.S.; providing for an executive director and employees of the office; providing duties and responsibilities of the executive director; providing for submission of a budget to the Financial Services Commission; providing for the location, internal administration, and operation of the office; creating s. 350.073, F.S.; providing for appointment, term, qualifications, and salary of the executive director of the office; providing for application of specified provisions for standards of conduct; creating s. 350.074, F.S.; providing duties of the office; authorizing the office to intervene in certain proceedings; requiring the office to provide an annual report to the Legislature; directing the commission and the office to establish procedures by which the office may elect not to participate as a party in certain matters; transferring from the commission all powers, duties, functions, records, offices, personnel, property, pending issues, and existing contracts, administrative authority, administrative rules, and unexpended balances of funds not related to the duties and responsibilities of the commission to the office; creating s. 350.075, F.S.; authorizing the office to access certain books and records; amending s. 350.113, F.S.; revising authorized uses of the Florida Public Service Regulatory Trust Fund; amending s. 350.117, F.S.; authorizing the office to require reports; requiring a copy of any report provided to the commission to be provided to the office; authorizing the commission to request that the office perform management and operation audits of any regulated company; repealing s. 350.121, F.S., relating to commission inquiries and the confidentiality of business material; creating s. 350.122, F.S.; requiring persons testifying before the Public Service Commission to disclose certain financial and fiduciary relationships; providing that a determination by the commission that a violation occurred constitutes agency action for which a hearing may be sought; amending s. 364.016, F.S.; authorizing the office to assess a telecommunications company for certain travel costs; amending s. 364.02, F.S.; defining the term "office" as used in provisions relating to telecommunications companies; amending s. 364.15, F.S.; revising provisions authorizing the commission to compel changes to a telecommunications facility; amending s. 364.183, F.S.; providing that the office shall have access to certain records of a telecommunications company and may require a telecommunications company to file records, reports, or other data; specifying limitations on the authority of the commission to access records; providing for the office to maintain confidentiality; amending s. 364.185, F.S.; providing powers of the office to investigate and inspect telecommunications companies; removing such powers from the commission; amending s. 364.335, F.S.; revising the authority of the commission to institute a proceeding to determine whether the grant of a certificate of need concerning construction, operation, or

control of a telecommunications facility is in the public interest; amending s. 364.3376, F.S.; providing for the office to conduct certain investigations; amending s. 364.3381, F.S.; revising the authority of the commission to investigate allegations of certain anticompetitive practices; amending s. 364.37, F.S.; revising the authority of the commission to make such order and prescribe such terms and conditions with respect to controversies concerning territory to be served by a telecommunications facility; amending s. 366.02, F.S.; defining the term "office" as used in provisions relating to public utilities; amending s. 366.05, F.S.; authorizing the office to make certain purchases for examinations and testing; providing that the office shall have access to certain records and may require records, reports, or other data; specifying limitations on the authority of the commission to access records; authorizing the office to assess a public utility for certain travel costs; amending ss. 366.06, 366.07, 366.071, and 366.076, F.S.; removing authority of the commission to initiate certain proceedings or take certain actions upon its own motion; amending s. 366.08, F.S.; providing powers of the office to investigate public utilities; removing such powers from the commission; amending s. 366.093, F.S.; providing powers of the office to have access to records; specifying limitations on the authority of the commission to access records; providing for the office to maintain confidentiality; amending s. 366.82, F.S.; revising the authority of the commission to require modifications or additions to a utility's plans and programs; amending s. 367.021, F.S.; defining the term "office" as used in provisions relating to water and wastewater utilities; amending s. 367.045, F.S.; requiring a water or wastewater utility to provide notice to the office when it applies for an initial or amended certificate of authorization; providing for an objection and a request for a public hearing by the office; requiring the commission to give notice of certain actions upon petition of the office; amending s. 367.081, F.S.; revising the authority of the commission to fix rates of water and wastewater utilities or implement changes of such rates; amending s. 367.0814, F.S.; providing for a water or wastewater utility to request and obtain assistance from the office for the purpose of changing its rates and charges; revising the authority of the commission to authorize interim rates; directing the commission to request from the office any information necessary to complete a status report; amending ss. 367.0817, 367.082, 367.0822, and 367.083, F.S.; revising authority of the commission to initiate certain proceedings or take certain actions upon its own motion; amending s. 367.101, F.S.; providing that the commission shall, upon request, direct the office to investigate agreements or proposals for charges and conditions for service availability and report the results; amending s. 367.121, F.S.; revising powers of the commission; providing powers of the office; amending s. 367.122, F.S.; providing for the office to test meters; amending s. 367.145, F.S.; revising provisions for use of certain regulatory fees; amending s. 367.156, F.S.; providing powers of the office to have access to records; specifying limitations on the authority of the commission to access records; providing for the office to maintain confidentiality; amending s. 367.171, F.S.; revising provisions for jurisdiction of certain cases involving a utility that becomes subject to county regulation; amending s. 368.05, F.S., relating to gas transmission and distribution facilities; prohibiting the commission from initiating proceedings under specified provisions on its own motion; specifying limitations on the authority of the commission to access records; amending s. 368.061, F.S.; revising provisions for compromise of a civil penalty; revising the authority of the commission to initiate injunction proceedings; amending s. 368.103, F.S.; defining the term "office" as used in the "Natural Gas Transmission Pipeline Intrastate Regulatory Act"; amending ss. 368.106 and 368.107, F.S.; revising the authority of the commission to initiate certain proceedings or take certain actions concerning rates; amending s. 368.108, F.S.; providing powers of the office to have access to records; specifying limitations on the authority of the commission to access records; providing for the office to maintain confidentiality; amending s. 368.1085, F.S.; authorizing the office to assess a natural gas transmission company for certain travel costs; removing the authority of the commission to assess such costs; amending s. 368.109, F.S.; revising provisions for use of certain regulatory fees; amending ss. 403.519, 403.537, and 403.9422, F.S., relating to siting of electrical transmission lines; revising authority of the commission to initiate certain proceedings or take certain actions upon its own motion; amending ss. 196.012, 199.183, 212.08, 288.0655, 290.007, 364.602, 489.103, and 624.105, F.S.; conforming cross-references; providing an effective date.

First reading by publication (Art. III, s. 7, Florida Constitution).

By the Finance & Tax Council; and Economic Development & Community Affairs Policy Council; Representatives Murzin, Eisnaugle, and Holder—

CS/HB 7213—A bill to be entitled An act relating to capital formation for infrastructure projects; amending ss. 288.9621, 288.9622, and 288.9623, F.S.; conforming a short title, revising legislative findings and intent, and providing definitions for the Florida Capital Formation Act; conforming cross-references; creating s. 288.9627, F.S.; providing for creation of the Florida Infrastructure Fund Partnership; providing the partnership's purpose and duties; providing for management of the partnership by the Florida Opportunity Fund; authorizing the fund to lend moneys to the partnership; requiring the partnership to raise funds from investment partners; providing for commitment agreements with and issuance of certificates to investment partners; authorizing the partnership to invest in certain infrastructure projects; requiring the partnership to submit an annual report to the Governor and Legislature; prohibiting the partnership and the fund from pledging the credit or taxing power of the state or its political subdivisions; prohibiting the partnership from investing in projects with or accepting investments from certain companies; creating s. 288.9628, F.S.; creating the Florida Infrastructure Investment Trust; providing for powers and duties, a board of trustees, and an administrative officer of the trust; providing for the trust's issuance of certificates to investment partners who invest in the partnership; specifying that the certificates are redeemable for tax credits under certain conditions; authorizing the trust to charge fees; limiting the amount of tax credits issued and the amount of tax credits that may be claimed or applied against state taxes in any year; providing for the redemption or sale of certificates; providing for the issuance of the tax credits by the Department of Revenue; specifying the taxes against which the credits may be applied; limiting the period within which tax credits may be used; providing for the state's obligation for use of the tax credits; limiting the liability of the fund; requiring the department to provide a certain written assurance to the trust under certain circumstances; specifying that certain provisions regulating securities transactions do not apply to certificates and tax credits transferred or sold under the act; amending s. 213.053, F.S.; authorizing the department to provide tax credit information to the partnership and the trust; providing an effective date.

First reading by publication (Art. III, s. 7, Florida Constitution).

Reference

CS/CS/CS/HB 159—Referred to the Calendar of the House.

CS/CS/HB 187—Referred to the Calendar of the House.

CS/CS/HB 203—Referred to the Calendar of the House.

CS/CS/CS/HB 303—Referred to the Calendar of the House.

CS/CS/CS/HB 409—Referred to the Calendar of the House.

CS/CS/CS/HB 561—Referred to the Calendar of the House.

CS/CS/CS/HB 621—Referred to the Calendar of the House.

CS/CS/CS/HB 981—Referred to the Calendar of the House.

CS/CS/CS/HB 1239—Referred to the Calendar of the House.

CS/HJR 1399—Referred to the Rules & Calendar Council.

CS/CS/HB 1483—Referred to the Economic Development & Community Affairs Policy Council.

CS/HB 7181—Referred to the Calendar of the House.

House Resolutions Adopted by Publication

At the request of Rep. Schwartz—

HR 9039—A resolution recognizing April 16, 2010, as "Healthcare Decisions Day" in Florida.

WHEREAS, Healthcare Decisions Day is designed to raise public awareness of the need to plan ahead for health care decisions related to end-of-life care and medical decision-making whenever patients are unable to speak for themselves and to encourage the specific use of advance directives to communicate these important health care decisions, and

WHEREAS, the Florida Bar Association provides the specifics of Florida's advance directives law and offers a model form for patient use, and

WHEREAS, it is estimated that only approximately 20 percent of Floridians have executed an advance directive and that less than 50 percent of severely or terminally ill patients have an advance directive, and

WHEREAS, it is likely that a significant reason for these low percentages is that there is both a lack of public knowledge and considerable confusion about advance directives, and

WHEREAS, one of the principal goals of Healthcare Decisions Day is to encourage hospitals, nursing homes, assisted living facilities, continuing care retirement communities, and hospices to participate in a statewide effort to provide clear and consistent information to the public about advance directives, as well as to encourage medical professionals and lawyers to volunteer their time and efforts to improve public knowledge and increase the number of Floridians with advance directives, and

WHEREAS, other organizations throughout Florida are encouraged to endorse this event and express their commitment to educating the public about the importance of discussing health care choices and executing advance directives, and

WHEREAS, as a result of "Healthcare Decisions Day" in Florida, the hope is that more Floridians will have conversations about their health care decisions and execute advance directives to make their wishes known, and fewer families and health care providers will have to struggle with making difficult health care decisions in the absence of guidance from the patient, NOW, THEREFORE,

Be It Resolved by the House of Representatives of the State of Florida:

That April 16, 2010, is recognized as "Healthcare Decisions Day" in the State of Florida.

—was read and adopted by publication pursuant to Rule 10.16.

At the request of Rep. Porth—

HR 9053—A resolution recognizing April 15, 2010, as "Disability Awareness Day" in the State of Florida.

WHEREAS, in 2007, there were approximately 2.6 million disabled Floridians, and

WHEREAS, a disability can be physical, perceptual, intellectual, academic, or psychiatric and can be visible or hidden, and

WHEREAS, a disability affects an individual in many facets of daily living, including housing, employment, education, leisure, or personal care, and

WHEREAS, disabled individuals are a vital part of Florida in their roles as valued workers, civic leaders, business owners, veterans, students, family members, and friends, and

WHEREAS, advocacy and education are valuable tools for promoting policies that remove barriers and increase awareness regarding persons with disabilities, NOW, THEREFORE,

Be It Resolved by the House of Representatives of the State of Florida:

That April 15, 2010, is recognized as "Disability Awareness Day" in the State of Florida.

—was read and adopted by publication pursuant to Rule 10.16.

At the request of Rep. Legg—

HR 9083—A resolution recognizing the Florida Association for Behavior Analysis on its 30th anniversary and designating the week of September 6-10, 2010, as "Florida Behavior Analysis Week" in Florida.

WHEREAS, the Florida Association for Behavior Analysis is the nation's largest statewide organization committed to the promotion and support of behavior analysis, and

WHEREAS, for the past 30 years the Florida Association for Behavior Analysis has promoted the ethical, humane, and effective application of behavior principles in all aspects of society, including education, business, rehabilitation facilities, and government, and

WHEREAS, behavior analysis is a science-based, cost-effective approach for training teachers, parents, and caregivers to prevent and solve serious behavior problems, and

WHEREAS, behavior analysis has demonstrated its effectiveness for many applications, including the treatment of individuals with autism, teaching basic self-help skills and language to persons with developmental disabilities, and helping foster parents lovingly raise emotionally difficult children, and

WHEREAS, the behavior analysts who are members of the Florida Association for Behavior Analysis have diverse backgrounds, including consulting firms, state government programs, private therapy practices, and school administrations, and

WHEREAS, the Florida Association for Behavior Analysis holds an annual conference each fall as a forum for exchanging ideas and data-based research relating to behavior analysis, behavior therapy, performance management, and behavior management programming, NOW, THEREFORE,

Be It Resolved by the House of Representatives of the State of Florida:

That the Florida Association for Behavior Analysis is recognized for its 30 years of contributions to the field of behavior analysis and that the week of September 6-10, 2010, is designated as "Florida Behavior Analysis Week" in Florida.

BE IT FURTHER RESOLVED that a copy of this resolution be presented to the Florida Association for Behavior Analysis as a tangible token of the sentiments expressed herein.

—was read and adopted by publication pursuant to Rule 10.16.

At the request of Rep. McKeel—

HR 9087—A resolution recognizing the 2009-2010 Bartow High School Boys' Basketball Team, winners of the Florida High School Athletic Association Class 5A State Championship.

WHEREAS, with commitment, determination, and hard work, the 2009-2010 Bartow High School Boys' Basketball Team won the Florida High School Athletic Association Class 5A State Championship on March 4, 2010, at The Lakeland Center by beating Sickles High School by a score of 53 to 41, and

WHEREAS, along the way to claiming the State Championship title, the 2009-2010 Bartow High School Boys' Basketball Team compiled a 25-5 season record, and

WHEREAS, outstanding skill, sportsmanship, and competitiveness have been characteristics consistently demonstrated by Bartow Yellow Jackets teammates Weedlens Beauvil, Adrian Brackins, Roy'Quies Graham, Tevin

Grant, Deandre Joe, Richard Murvin, Reginald Polite, Vincent Reid, Rodrick Robinson, Jeremiah Samarrippas, Akeem Severin, Rodney Smith, Deone'Ta Levy, and Jordan White, and

WHEREAS, led by Head Coach Terrence McGriff and Assistant Coaches Marlon Austin, Ledarion Jones, Larry Tucker, Howe Wallace, and Robert Webb, the Bartow Yellow Jackets accomplished the team's goal to win the 5A state title, and

WHEREAS, the 2010 championship marks the fourth Florida High School Athletic Association State Championship for the Bartow High School Boys' Basketball Team, and

WHEREAS, it is with great pride that the 2009-2010 Bartow High School Boys' Basketball Team is applauded for the numerous accomplishments of its players and coaches, NOW, THEREFORE,

Be It Resolved by the House of Representatives of the State of Florida:

That the Florida House of Representatives honors the 2009-2010 Bartow High School Boys' Basketball Team for their outstanding record and for winning the 2010 Florida High School Athletic Association Class 5A State Championship.

BE IT FURTHER RESOLVED that a copy of this resolution be presented to the 2009-2010 Bartow High School Boys' Basketball Team as a tangible token of the sentiments expressed herein.

—was read and adopted by publication pursuant to Rule 10.16.

Reports of Standing Councils and Committees

Received April 14:

The Criminal & Civil Justice Policy Council reported the following favorably:
CS/HB 187 with council substitute

The above council substitute was transmitted to the Office of the Speaker, subject to referral under Rule 7.20. Under the rule, CS/HB 187 was laid on the table.

The PreK-12 Appropriations Committee reported the following favorably:
CS/HB 1287 with committee substitute

The above committee substitute was transmitted to the Office of the Speaker, subject to referral under Rule 7.20. Under the rule, CS/HB 1287 was laid on the table.

The Criminal & Civil Justice Policy Council reported the following favorably:
HB 7181 with council substitute

The above council substitute was transmitted to the Office of the Speaker, subject to referral under Rule 7.20. Under the rule, HB 7181 was laid on the table.

Received April 15:

The General Government Policy Council reported the following favorably:
CS/CS/HB 159 with council substitute

The above council substitute was transmitted to the Office of the Speaker, subject to referral under Rule 7.20. Under the rule, CS/CS/HB 159 was laid on the table.

The General Government Policy Council reported the following favorably:
CS/CS/HB 163

The above council substitute was placed on the Calendar of the House.

The General Government Policy Council reported the following favorably:
CS/CS/HB 311 with council substitute

The above council substitute was transmitted to the Office of the Speaker, subject to referral under Rule 7.20. Under the rule, CS/CS/HB 311 was laid on the table.

The General Government Policy Council reported the following favorably:
CS/HB 821

The above committee substitute was placed on the Calendar of the House.

The General Government Policy Council reported the following favorably:
CS/HB 845

The above committee substitute was placed on the Calendar of the House.

The General Government Policy Council reported the following favorably:
CS/HB 1035

The above committee substitute was placed on the Calendar of the House.

The General Government Policy Council reported the following favorably:
HB 1065

The above bill was placed on the Calendar of the House.

The Finance & Tax Council reported the following favorably:
CS/HB 1095 with council substitute

The above council substitute was transmitted to the Office of the Speaker, subject to referral under Rule 7.20. Under the rule, CS/HB 1095 was laid on the table.

The General Government Policy Council reported the following favorably:
CS/HB 1253

The above committee substitute was placed on the Calendar of the House.

The General Government Policy Council reported the following favorably:
CS/HB 1299 with council substitute

The above council substitute was transmitted to the Office of the Speaker, subject to referral under Rule 7.20. Under the rule, CS/HB 1299 was laid on the table.

The General Government Policy Council reported the following favorably:
CS/HB 1385 with council substitute

The above council substitute was transmitted to the Office of the Speaker, subject to referral under Rule 7.20. Under the rule, CS/HB 1385 was laid on the table.

The Criminal & Civil Justice Policy Council reported the following favorably:

HB 1449 with council substitute

The above council substitute was transmitted to the Office of the Speaker, subject to referral under Rule 7.20. Under the rule, HB 1449 was laid on the table.

The General Government Policy Council reported the following favorably:
HR 1613

The above resolution was transmitted to the next council or committee of reference, the Rules & Calendar Council.

The General Government Policy Council reported the following favorably:
CS/HB 7179

The above council substitute was placed on the Calendar of the House.

The General Government Policy Council reported the following favorably:
CS/HB 7209 with council substitute

The above council substitute was transmitted to the Office of the Speaker, subject to referral under Rule 7.20. Under the rule, CS/HB 7209 was laid on the table.

The General Government Policy Council reported the following favorably:
HB 7211

The above bill was placed on the Calendar of the House.

The Finance & Tax Council reported the following favorably:
HB 7213 with council substitute

The above council substitute was transmitted to the Office of the Speaker, subject to referral under Rule 7.20. Under the rule, HB 1449 was laid on the table.

Communications

The Governor advised that he had filed in the Office of the Secretary of State the following bills which he approved:

April 14—CS/HB 437 and HB 689

The Honorable Kurt S. Browning April 14, 2010
Secretary of State

Dear Secretary Browning:

Enclosed for filing is an act that originated in the House during the 2010 Session, which I approved today:

CS HB 437	Contingency Fee Agreements Between the Department of Legal Affairs and Private Attorneys
HB 689	Negligence

Sincerely,
CHARLIE CRIST
Governor

Excused

Reps. Braynon, Weinstein, Van Zant

Adjourned

Pursuant to the motion previously agreed to, the House adjourned at 5:53 p.m., to reconvene at 12:30 p.m., Monday, April 19, 2010, or upon call of the Chair.

CHAMBER ACTIONS ON BILLS

Thursday, April 15, 2010

CS/HB 109 — Read 3rd time; CS passed; YEAS 114, NAYS 0

CS/CS/HB 119 — Read 3rd time; CS passed as amended; YEAS 115, NAYS 0

CS/HB 143 — Read 3rd time; CS passed; YEAS 114, NAYS 0

CS for CS for SB 350 — Read 3rd time; CS passed; YEAS 114, NAYS 0

CS/HB 451 — Read 3rd time; CS passed as amended; YEAS 114, NAYS 0; Amendment 000511 adopted

CS/HB 569 — Read 3rd time; CS passed as amended; YEAS 110, NAYS 5

CS/CS/HB 747 — Read 3rd time; CS passed; YEAS 113, NAYS 0

CS/HB 1101 — Read 3rd time; CS passed; YEAS 113, NAYS 0

CS/HB 1225 — Read 3rd time; CS passed; YEAS 113, NAYS 0

CS/HB 1281 — Read 3rd time; Amendment 013005 adopted; CS passed as amended; YEAS 114, NAYS 0

CS/HB 1291 — Read 3rd time; CS passed; YEAS 111, NAYS 0

CS/HB 1537 — Temporarily postponed, on 3rd Reading

HB 7079 — Read 2nd time

HB 7085 — Read 2nd time

HB 7087 — Read 2nd time

HB 7089 — Read 2nd time

HB 7091 — Read 2nd time

HB 7093 — Read 2nd time

CS/HB 7099 — Read 3rd time; CS passed as amended; YEAS 111, NAYS 0

HB 7111 — Read 2nd time

HB 7113 — Read 2nd time

HB 7115 — Read 2nd time

HB 7117 — Read 2nd time

HB 7119 — Read 2nd time

HB 7121 — Read 2nd time

HB 7123 — Read 2nd time

HB 7153 — Read 3rd time; Passed; YEAS 116, NAYS 0

CS/HB 7165 — Read 2nd time

HB 7167 — Read 2nd time

HB 7193 — Read 2nd time

HB 7223 — Read 2nd time; Amendment 385527 Failed; Amendment 779459 adopted; Amendment 528329 adopted; Amendment 751373 adopted; Amendment 278761 adopted; Amendment 727969 adopted; Amendment 443703 adopted; Amendment 910699 adopted; Amendment 959815 adopted; Amendment 458073 adopted; Amendment 123519 adopted; Amendment 233951 adopted; Amendment 978065 adopted; Amendment 893659 adopted; Amendment 793097 adopted; Amendment 400337 adopted; Amendment 573241 adopted; Amendment 520401 adopted; Amendment 647097 adopted; Amendment 880361 adopted; Amendment 753967 adopted; Amendment 591297 Failed; Amendment 612241 Failed; Amendment 785819 adopted; Amendment 544071 adopted; Amendment 712231 adopted; Amendment 733217 adopted; Amendment 637061 adopted; Amendment 465831 adopted; Amendment 015355 adopted; Amendment 200861 adopted; Amendment 355159 Failed

HB 7225 — Read 2nd time; Amendment 311719 adopted; Amendment 937479 adopted; Amendment 318509 adopted; Amendment 304175 adopted; Amendment 436503 adopted; Amendment 570143 adopted; Amendment 054651 adopted; Amendment 362273 adopted

JOURNAL OF THE HOUSE OF REPRESENTATIVES

DAILY INDICES FOR

April 15, 2010

NUMERIC INDEX

JOURNAL OF THE HOUSE OF REPRESENTATIVES

SUBJECT INDEX